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1. EXECUTIVE SUMMARY

The Impact of HIV/AIDS on Small and Medium Enterprises (SMEs) was carried out in two Phases. Phase two was carried out between January and April 2002 by a multidisciplinary team from Ebony Consulting International (Pty) Ltd. (ECI). The survey team visited a stratified sample of 120 SMEs in Gauteng, Cape Town and Durban. This sample included 71 firms from Gauteng, 24 firms from Cape Town and 25 firms from Durban. The sample was primarily selected from the firms that participated in ECI's 1999 GTZ study that focused on understanding key attributes or personal entrepreneurial competencies of successful high growth SME owners/managers.

The objective of Phase two was two-fold: Firstly, to improve the data gathering methodology by incorporating lessons learnt from Phase one. The Phase one survey instrument had a number of questions, which were very prescriptive. It became apparent during the analysis stage that it was difficult for the team to make concrete conclusions on certain questions because of the way they had been phrased. The questions in the Phase one survey instrument would not enable the team to subject the entire sample to establish how susceptibility and/or vulnerability to HIV/AIDS our entire sample was.

Following our presentation of Phase one interim findings to the Joint Centre at a workshop, ECI was invited by the South African Business Coalition on HIV/AIDS (SABCOHA), the American Chamber of Business (AMCHAM), a Cape Town based community development organisation (Goegdechact Trust) and USAID, to present their findings once again. All the inputs obtained from these presentations further helped us in redesigning our survey instrument for use in Phase two.

The second objective of Phase two was to follow up the same sample from Phase one to investigate changes in variables such as:

- Personal HIV/AIDS awareness and responses versus business responses
- Effects cited by the firms including employee, absenteeism, deaths
- HIV/AIDS mitigation activities
- Susceptibility and vulnerability of firms, etc.

With an exception of 23 replacement firms, the sample comprised the same firms interviewed in Phase one. Reasons for replacing firms included unwillingness to participate in this second round of interviews, failure to locate firms, as well as closure of some operations.

The study revealed the following key issues:

- General perceptions of the impact of HIV/AIDS

Most owner/managers are aware of the potential impact of HIV/AIDS, either individually or at firm level. The overall perception is that HIV/AIDS is affecting the health, social, and economic spheres of South African society.

- Availability of workplace programmes

The study showed that there was an encouraging move, by SMEs, towards more "formal" types of workplace activities when compared to Phase one. The big challenge, however, is that there are still very few firms with workplace programmes overall.

- Constraints to mitigation

Most owner/managers believe they should be doing "something" to mitigate the effect of HIV/AIDS within their workplace. Most of these cited lack of time and/or skills to do so, as the main hinderance hampering their intentions to implement workplace HIV/AIDS programmes.

- Costs Cited

Overall, the majority of firms are not citing direct costs related to HIV/AIDS. Most firms are mainly citing indirect costs, and absenteeism emerged as the one cited most. However, when the entire sample is "risk profiled" [1], to understand how susceptible or vulnerable they are to HIV/AIDS, most of the firms (including those not citing costs) have more than 50% of their full time employees falling within the "most susceptible" age group.

It is also important to note that firms in Durban (KZN) cited more costs than firms from Gauteng and Cape Town. This is in relation to their representation in the sample.

- We believe interviewing the same firms over a longer period of time would produce more meaningful findings. Thus taking into account the nature of the disease "long-wave effect".

Based on issues that have emerged from this study, we recommend that:

- There is need to focus research to understand the constraints in workplace programme implementation being faced by SMEs, in order to help them with more practical solutions such as designing and implementation of HIV/AIDS programmes.
- There is a need to increase the level of awareness on HIV/AIDS-SME issues amongst policy makers and implementers
- Closer co-operation between DTI, and "frontline" HIV/AIDS organisations must be encouraged in order to leverage resources and share best practices.
- Other existing infrastructure such as Local Business Service Centers (LBSCs) should be used to disseminate information on HIV/AIDS (targeted at SMEs) to the SMEs.

[1] We profiled firms in terms of number of staff within the most "risky" age group only. Not sufficient to make solid conclusions, but just provides another way of approaching the study. The advantage is that it allowed the team to look at the entire sample as opposed to looking at only those firms citing costs.

2. INTRODUCTION

The increasing prevalence of HIV/AIDS in South Africa threatens to undermine the progress of SMEs who are currently contributing to the economic diversification of the South African economy. This statement is predicated on the fact that HIV/AIDS affects individuals in a chronic and debilitating manner, is indiscriminate of such basic demographic indicators as age, race, and sex/gender, and has particularly devastating implications for both productive (in terms of the combined value of their productive contribution) as well as for non-productive members of society (in terms of the potential cost burden born by the state in treating these individuals). When one looks at the equation from the standpoint of supporting non-productive members of society however, one realises that for an economy to be able to manage such an impact, this ability must be measured in terms of the resources it has at it's disposal, and therefore what it is able to produce. An under-producing economy is at greater risk of having less financial flexibility with which to react to economic shocks. It is for this reason that measuring the impact of HIV/AIDS, in terms of the affects on productive members of society and the organisations that employ them, is of significant importance.

What has been described means little without a more realistic picture of the status of HIV/AIDS impact in South Africa, otherwise AIDS should not be treated as different from any other debilitating condition. UNAIDS estimated that at the end of 1999 close to 20% of the adult population of South Africa (15-49 years of age) were living with HIV[2]. While the number of deaths from AIDS in South Africa so far is modest in comparison to HIV prevalence rates, adult mortality due to the maturation of HIV infection into full blown AIDS is projected to increase through the decade, with an accumulated estimate of over six million deaths due to HIV/AIDS by 2010.[3] As the above prevalence data suggests, the effect of HIV/AIDS on the adult population and by extension the human economic assets of the country can be particularly devastating for sustained and continued economic growth at a macro level, and for stimulating and creating job and other income generating opportunities for the country's poor. At the micro level, small and medium enterprises, and the entrepreneurs who drive them are seen as the engines of more diversified and balanced job creation.

3. BACKGROUND

In 1999, ECI surveyed owners/managers of 64 high growth SMEs countrywide to document key attributes and entrepreneurial success factors. The study collected critical information on the perceived cause(s) or "big breaks" resulting in success, as well as the gaps in financial and business development services that constrain growth and expansion. Given the increasing prominence of HIV/AIDS as a potential and real threat to SME growth, and in response to the Call for Concept Papers from the Joint Centre for Political and Economic Studies, ECI proposed, and was later commissioned, to conduct a survey of SMEs modelled on the survey completed in 1999. The project was designed to address the awareness and impact of HIV/AIDS on SMEs, and included two surveys one year apart (2001 and 2002) to identify and then track changes in relation to the impact on firms, as well as mitigation activities associated with HIV/AIDS.

This report will first provide an outline of the objectives of this study, the lessons learned from Phase one and the specific research questions being addressed. The research methodology is then explained addressing various issues such as sampling, definitions and classifications, survey design, pilot testing, data collection, monitoring of data collection, data processing and data analysis. The key findings of the survey in the second Phase are then presented. The last section deals with a comparative analysis of the data gathered in the first and second Phases of this

[2]UNAIDS, http://www.unaids.org/hivaidsinfo/statistics/fact_sheets/pdfs/Southafrica_en.pdf
[3]Medical Research Council, 2001: http://www.mrc.ac.za/bod/complete.pdf

research project. Conclusions and recommendations are then made based on the findings from both Phases one and two.

3.1 OBJECTIVES OF THE STUDY

The general objective of this study is to investigate the impact of HIV/AIDS on SMEs. This is a longitudinal study comprised of two Phases: Phase one which was conducted in February 2001, the findings of which are annexed in this report, investigated the awareness level, effects cited, and mitigation activities of firms, related to HIV/AIDS.

The data from Phase one produced a working methodology based on three primary research questions:

- The awareness level amongst firms, at an individual (management) and firm level;
- The frequency of costs cited and the type of costs experienced, i.e. direct versus indirect costs; and
- Mitigation activities, including HIV/AIDS policies, and specific types of workplace interventions.

We expanded our investigation in Phase two as we acknowledged that it was limited to the process of making comprehensive recommendations to focus our scrutiny on those firms that reported an "effect" only. Rather given health, legislative and social constraints, determining an AIDS effect within these firms, we needed to subject the entire sample to indicators of susceptibility and vulnerability to highlight the importance of managing an impact BEFORE it happens. Methodologically, this has the advantage of subjecting our entire sample to the same indicators regardless of whether an impact is cited, so that we derive more practical insights into the need for and design of HIV/AIDS workplace planning and support interventions.

Phase two has two objectives: the first is making use of what was learned in Phase one to redesign the questionnaire focusing more on "risk profiling" firms by asking descriptive questions including:

- Proportion of workers by skill levels;
- Labour-related expenditure as a proportion of total expenditure;
- More detailed questions on the provision of staff benefits; and
- Detailed questions about the development and composition of HIV/AIDS interventions including policies.

The second objective of Phase two is to compare variables between Phases one and two to investigate changes in:

- Personal awareness of the effects of HIV/AIDS versus business awareness;
- Turnover and net profit information;
- Effects cited due to HIV/AIDS including employee deaths;
- HIV/AIDS interventions;
- Effects on clients;
- Employee absenteeism; and
- Skills identification and retention.

3.2 EXPANDED RESEARCH QUESTIONS

Question 1: What can looking at demographic indicators such as age segment, geographical location, sector, and skills profiles of firms, mitigation activities and HIV/AIDS policies tell us about their susceptibility and vulnerability to effect?

The importance of this questions is that it provides indicators to measure the susceptibility and vulnerability of firms to managing the impact of HIV/AIDS. The real value in this research is not in being able to cite "X % of firms citing costs, but rather to profile the entire sample according to generally acceptable indicators of vulnerability and susceptibility, thereby aiming to contribute to the utility of research measurements and methods. It also sensitises support organisations and SMEs themselves to the importance of using these indicators in their support interventions and strategic/business planning respectively.

Question 2: What types of interventions and activities are observed and what are the implications thereof?

It is very important to track the frequency of HIV/AIDS policies and activities/interventions being implemented by firms. We propose to ask a range of more detailed questions that will assist us in having a more in-depth understanding of not only whether firms have these in place, but how activities were chosen, and developed, both internally and externally.

Question 3: How do revenue and expenditure profiles affect the risk of HIV/AIDS and the management thereof?

The importance of this question is that it provides us with data on important growth and sustainability variables such as turnover and net profit, this indicates the vulnerability of a firm in managing potential direct costs of HIV/AIDS. The proportion of expenditure devoted to labour could also show more or less vulnerability to HIV/AIDS depending on labour/capital intensity in a firm. The point however is that these are important methodological questions designed to measure how at risk a firm is at managing the impact of HIV/AIDS.

Question 4: What types of costs being cited? What can they tell us about the efficacy of making an HIV/AIDS connection? What are the profile of firms citing costs?

The importance of this question rests in the frequency of costs cited which immediately provides us with information on whether the frequency and types of costs have changed? If so, can we say something about the types of firms consistently experiencing costs related to elevated risk profiles, i.e. related to labour profile as well as industry and regional representation?

Question 5: What is the availability, and use by SMEs, of information pertaining to HIV/AIDS and business?

The importance of this question is that it illustrates not only the initiative, or lack thereof, of SME managers/owners to obtain such information as well as to act on this information, but also can be used to consider whether such information is accessible or publicised enough. This question would be useful for SME support organisations, HIV/AIDS service providers, and funders, in terms of understanding the gaps and limitations in workplace information and Aids service providers.

Question 6: What is the key theme of SME recommendations?

Just as important as the more quantitative information is capturing information on what ultimately drives businesses/entrepreneurs to act with respect to HIV/AIDS education, awareness, treatment and other activities.

4. METHODOLOGY

Our methodology was based on a semi-structured sample survey of 120 small and medium enterprises. The primary objective was to interview all firms that participated in the Phase one survey in order to investigate changes in HIV/AIDS perceptions, effects and mitigation activities. We anticipated that for reasons beyond our control, we were likely to experience cases where firms interviewed in 2001 either would not wish to participate in a second survey, have closed down/changed their activities, or simply could not be located. In order to maintain sample size, we replaced firms where necessary.

4.1 Sampling

Our sample was largely determined by our concept, which was to interview an existing sample of firms that participated on a previous ECI project investigating high growth SMEs. This project also provided us with the sampling frame from which to identify, locate and contact firms for the HIV/AIDS project. Given that the sample frame only provided us with just over half of the firms we required to meet our sample size, we had to employ non-probability sampling to make up the difference.

A more subjective sampling approach was employed given factors such as budget constraints that limited the sample size to that which could not be considered representative and the experimental nature of the research within the context of the "Call for Concept Papers". The research was viewed as a first step to investigating and developing a methodology to investigate a new dimension of the impact of HIV/AIDS (i.e. on SMEs). The aforementioned reasons together with our being able to leverage our extensive knowledge, network, and practical associations with SME clients into the choice of appropriate firms, we felt that being more subjective in our sampling was most practical, however based on some minimum selection criteria to delineate the parameters of our sample population. Our supplementary frame included SME clients recommended by our business linkage consultants from our client database as well as referring to the publication: "Top 300 Black Empowerment Firms", which documents some of South Africa's most highly regarded PDI enterprises.

Our minimum selection criteria included:

- Have at least 2 years of operating history;
- Be registered for tax, VAT, and other statutory requirements;
- Have 5 employees or more, with a maximum of 200;
- Have an annual turnover greater than R150 000; and
- Must have a moveable asset value greater than R100 000, and less than R5 million.

In Phase one, the total sample size was approximately 150 firms. After final screening, approximately 130+ owner/managers were targeted for interviews, with eventually 120 firms being interviewed and analysed. Our total sample size for Phase two was then 120 firms, based on the re-survey of Phase one firms.

4.2 Stratification

Our stratification variables were industry sector and geographical location. The rationale for a geographical stratification was based on the sample taken from the 1999 GTZ survey to more easily access firms located in the three major industrial areas of the country, namely greater Gauteng region, Cape Town, and Durban. All the firms interviewed operate in urban and peri-urban areas. Approximately 50 per cent of the firms are from the greater Gauteng region, 25 percent from Durban and 25 per cent from Cape Town. Sector stratification achieved two analytical purposes: first to cross analyse sectors to get a broader spectrum of data on HIV/AIDS and SMEs; and secondly to cluster firms by sector to obtain comparative statistics not only on impact but also on risk profiles according to the indicators outlined above

4.3 The Survey Instrument

The survey instrument was significantly altered to address the lessons learned in Phase one. It was also restructured to place greater emphasis on "risk assessment" so that all firms interviewed regardless of citing affects/costs due to HIV/AIDS would be subjected to specific questions designed to comprise their susceptibility and vulnerability profiles. These included:

- Employee description by skills classifications;
- Demographic information such as age and marital status;
- Skills identification and retention;
- Comparative expenditure profile (focussing on labour-related expenditure);
- Benefits assessment;
- HIV/AIDS policy and policy development within business; and
- HIV/AIDS interventions and types of interventions.

Although we anticipated and expected to interview all firms that participated in Phase one, we were aware of the reality that firms either would decline participation in a second survey; or that some firms may have, due to a variety of possible reasons, ceased operations. In such cases we documented the reasons for non-participation, and endeavoured to interview new firms to maintain the intended sample size as well as broaden our coverage. In the end, we obtained an 81% response rate.

4.4 Data Collection

The draft questionnaire was piloted with six (6) SMEs in Gauteng. As in Phase one, the purpose of the pilot was used to check for snags in the administration and sequencing of the questions and sections, as well as to identify questions that were difficult or ambiguous to administer. The pilot surveys also gave the researchers the opportunity of familiarising themselves with the questionnaire in the interview context. For the field survey, the data was collected via physical visits to the premises of SMEs i.e. person-to-person interviews. Data collection was carried out by the project team who designed the questionnaire, with the assistance of Dr. Coetzee. As a measure of consistency in the data capturing, a definition sheet was drawn up to accompany the questionnaire for the interviewer and interviewee to refer to when needed. (See Annex 3.)

Data was captured via laptop computers and merged into a single data set following individual cleaning by each researcher. Following the data merger into one data set, data was cross checked and cleaned a second time and any discrepancies were directed at the appropriate researcher before finalisation of data for analysis.

The other equally important component will be to set up workshops to discuss the findings of both Phases with the participating SMEs. These sessions will be designed to be interactive and elicit the thoughts of the SMEs on the subject of HIV/AIDS in the workplace, the project itself, and importantly ways in which SMEs can better manage the potential impact themselves, as well as

what kind of support/assistance is needed. The purpose is to present our findings and engage the relevant stakeholders in discussions to generate ideas about addressing and confronting the impact of AIDS on SME development. The differences in how businesses are addressing the AIDS issue makes this type of gathering particularly appealing, as it is designed to encourage debate and exchange between firms that are approaching and managing the potential, and real, effects of HIV/AIDS in varying ways, and according to their unique circumstances and experiences.

4.5 KEY CHALLENGES TO THE FIELD RESEARCH

Identifying AIDS-related indicators: The 'long-wave effect' of HIV/AIDS implies that the impact of the disease is not readily detectable. A range of issues still precludes disclosure of HIV status in most segments of South African society. For instance, to the question "why would your employees choose not to disclose their HIV status?" 42.2% of the respondents cited the stigma attached to the disease as the main problem. This veil of secrecy poses a key challenge to any study of this nature when making concrete conclusions regarding the actual impact of HIV/AIDS.

To overcome this hurdle, the survey instrument was redesigned to include questions that target the susceptibility and vulnerability of the SMEs to HIV/AIDS.[4] In addition, the study drew upon UNAIDS guidelines for the assessment of the institutional susceptibility and vulnerability of selected SMEs to HIV/AIDS.[5] The modality of the disease's infection path suggests some companies would be more susceptible to HIV/AIDS than others. Such SMEs would specifically include transport enterprises and businesses that require their employees to travel widely, or rely upon migrant labour. Employees working away from home are more likely to engage in risky behaviour (e.g. use of sex workers, casual sexual partners, etc) and thus increase their susceptibility. These enterprises were expected to be more likely to have already been affected by HIV/AIDS due to the nature of their operations.

Setting up interviews: There was some difficulty meeting with entrepreneurs (either owners or managers) because of their busy schedules, this contributed to prolonging the fieldwork. Experience shows however that this pattern of behaviour is normal for particularly small companies where owners are sometimes very involved in almost all aspects of running the business. Sometimes those entrepreneurs we managed to find in the office would indicate that they would only be available to be interviewed after two to three weeks. In order to overcome this challenge, the survey team set up interviews concurrently with field surveying. Only an insignificant number of cancellations were experienced. This could be attributed partly to the importance that a number of entrepreneurs attached to the survey, but overall, the relationships which ECI has established with SMEs through the business linkage programmes were highly beneficial. However, the firms are now starting to offer resistance when asked for interviews, as they have not received tangible feedback related to their answers to the questionnaire.

Finding replacement firms: Overall, the research team succeeded in setting up interviews with about 81% of the firms interviewed in Phase one. However, it was not possible to track down all the firms that participated in Phase one due to reasons ranging from closure, change of contact details and/or location of offices, and sometimes unwillingness on the part of certain entrepreneurs to take part in the study. Also given time constraints on their part, certain entrepreneurs had

[4] The distinction is made between susceptibility and vulnerability because a SME might be susceptible (i.e. predisposed to infection) but not vulnerable (i.e. ability to mitigate the excess morbidity and mortality associated with disease). Economic impact studies should clearly show whether and how each industry contributes to susceptibility and whether and how it is vulnerable to the impact of the disease. See Barnett T & A Whiteside, *Guidelines for Studies of the Social and Economic Impact of HIV/AIDS*. UNAIDS, Geneva, 2000, p. 9 and 10.

[5] Barnett T & A Whiteside, *Guidelines for Studies of the Social and Economic Impact of HIV/AIDS*. UNAIDS, Geneva, 2000, p. 27 and 30.

requested to complete the questionnaire on their own. Unfortunately, they either did not do so or the completed questionnaires did not reach ECI offices.

More specifically, out of the 29 firms interviewed during Phase one in Durban, three firms have closed. One of the firms closed its operations due to its inability to sustain the fixed costs with the poor revenue. Another firm has closed down because the owner committed suicide, while the owner of the other firm has closed in order to take up full-time employment at Spoornet. In Cape Town one firm out of 28 firms interviewed last year closed down for an unknown reason. In Gauteng, the team did not track down 19 firms mainly due to change of contact details or physical locations. The team did not verify whether these firms had closed or not.

To help overcome this, the team conducted physical visits to the offices of such firms (based on the contact details given in Phase one). We also consulted the Yellow Pages and the Telkom's Directory Services to try and track down these firms. After these efforts proved futile, the team replaced the relevant firms with new firms using the SME databases from ECI's two long term business linkage programmes (South African International Business Linkages Programme (SAIBL) and the Tourism Enterprise Programme (TEP)).

Measurability/Quantifiability: The nature of this research is such that it is very difficult to quantify the results. SMEs generally have informal management policies, record keeping and records on staff issues. This has made the task of gathering measurable information difficult. In order to measure the economic impact of HIV/AIDS on SMEs it is also necessary to gather detailed financial information on expenditure. The lack of good financial records and the unwillingness to share this information with us in some cases made measuring the impact very difficult. As a result we had to take a different angle on the research in terms of studying what makes firms more susceptible and vulnerable to the impact of HIV/AIDS. It is therefore also necessary to do further in depth analysis on the indirect costs. Since these costs are not measurable more needs to be known about the burden they place on the business operationally, financially, emotionally, psychologically and socially.

Sample size: The size of the sample (120 firms) makes it impossible to draw specific conclusions about HIV/AIDS and SMEs in South Africa as a whole. However, it is very useful in showing what the important issues are, and highlighting what further analysis needs to be done.

Questionnaire: The re-design of the questionnaire was a very good learning experience for the whole team. The original questionnaire served the purpose of showing what further questions needed to be asked and which areas need more probing and data gathering to optimally collect the relevant information and core issues. The second Phase questionnaire was redesigned re-looking at the overall objectives and the lessons learned from the first Phase. As a result, not all of the questions are entirely comparable to the first Phase questions, but common themes run through both questionnaires, and the second Phase questionnaire highlights these and goes into more depth.

5. DESCRIPTION OF SAMPLE

This section describes the sample of the 120 firms that participated in Phase two. It aims to provide an organizational profile of the firms looking at variables such as legal status, industry representation, firm size (total full-time employees), turnover, net profit, demographics of employees, as well as a breakdown of client profiles.

5.1 Employee Demographics

The sample of 120 firms was composed of a total full-time employee complement of 3839 individuals, averaging approximately 32 employees per firm. This figure represents an average of 32 employees per firm. In terms of ethnicity, the majority of employees (including management) were Black (approximately 70%), whereas the education levels of employees (including management) show that most have only completed matric (80%).

Table 1 shows the age breakdown of full time employees (including management/owners). The age composition and distribution of staff is a significant variable to monitor in the economics of HIV/AIDS research. Many studies[6] have looked at HIV prevalence across different age groups, and although these differ slightly in terms of their focus on specific parameters of age bands used, they all show that as a rough category those individuals between the ages of 15 and 40 have shown comparably higher prevalence rates. For the purpose of this study, we decided to fix the parameter for the "most susceptible" age category between 21-35 years of age, increasing the minimum from 15 so as to allow for working age individuals. Our sample showed that only1,33% of employees were below the age of 21. We fixed the maximum group at 35 where prevalence rates tended to plateau and then decrease. A comparison across the groups shows that the highest concentrations of staff fell within the 26-30 and 31-35 age groupings, and combined, approximately 67% or ⅔rds of the employees fell within 21-35. It is also important to note that this very susceptible age group is also the age group that is most economically active and responsible for generating household incomes. We will continue our discussion of age segmentation as a factor in HIV/AIDS susceptibility in Section 7.

Table 1: Age breakdown of full time employees (including management)

Category	Percentage (%)	Number of Firms (#)
< 21	1.33	46
21-25	**14.41**	**499**
26-30	**24.86**	**861**
31-35	**28.95**	**1003**
36-45	21.56	747
> 45	8.89	308
Total	**100**	**3464**

*N=3464 (not all employees ages were known)

[6] See "Impending Catastrophe Revisited: an Update on the HIV/AIDS epidemic in South Africa", Love Life, 2001; and "The Impact of HIV/AIDS on Adult Mortality in South Africa", Medical Research Council, 2001.

5.2 Legal status and Industry representation

Our sample shows that most firms (88%) are registered either as Closed Corporations or Private Companies (approx. 38% and 50% respectively), with the remainder consisting of sole traders (10%), not-for-profit organisations and others (2%).

This section provides an overview of industry representation necessary to see how many firms from our sample fall within what is classified as the most susceptible industries based on the following quote:

> "The highest rates of infection are to be found in some of the more important industries in our economy such as transport and mining. Both are severely affected because of the way the industries are structured and the socioeconomic factors, which impact on employees. Large numbers of men are away from their homes and wives for prolonged periods. In such industries, the rate of infection is likely to be up to 65%".[7]

Table 2: Industry representation

INDUSTRY	**Percentage (%)**	**Number (#)**
Agriculture	1.7	2
Manufacturing	**30**	**36**
Construction	0.8	1
Retail trade	5	6
Wholesale trade	3.3	4
Transportation	4.2	5
Financial/professional services	**24.2**	**29**
General services	**30.8**	**37**
Total	**100**	**120**

5.3. Size of the firms by full time staff (includes owner/manager)

It was highlighted in the opening sentences of this section that the sample of the firms interviewed together employed a total of 3839 full time employees, with each firm representing on average 32 employees. This section further breaks down these firms into small or medium. The significance of this will be more evident in Section 7 where an analysis of these firms in relation to whether, and how, they are being impacted by HIV/AIDS, their ability to afford or access necessary resources to mitigate the potential impact of the disease within their businesses, and/or the type of assistance they require. The section on definitions, in Annex 3, has clearly defined the differences between a small and medium firm. The definition is based on the 1996 National Small Business Act. Table 3 shows the breakdown between small and medium firms in our sample.

Table 3: Distribution of firms as small and medium based on size of full time staff

Size Class	**% (percentage)**	**# (frequency)**
Small	82.5	99
Medium	16.7	20
Total	119	119

*N = 119 (one firm did not give employee numbers)

[7] Rose Smart, Aids and business in 2002, Succeed Magazine special publication, 2002, p4-5

5.4 Annual Turnover and Net Profit of firms

Annual Turnover

While it is not our intention to link a firm's drop in turnover to HIV/AIDS, it is widely accepted that HIV/AIDS will begin to impact business' turnover when it starts affecting their markets significantly. This section does not discuss this, but Section 8, which makes a comparison on the effects of HIV/AIDS being cited by the firms over a period of two years, has looked at this. The aim of this section is therefore to merely provide a description of the spread in turnover of the sample under investigation. Table 4 presents the distribution of the sample by Turnover. Apart from the spread of firms indicated here, we were not able to obtain this information from almost 23% of the firms. This was due to a combination of factors including firms not wishing to disclose this type of information as well as eventual non-responses from businesses that did not have this information available at the time of interview and who indicated they would provide us with this subsequently.

Table 4: Distribution of firms by annual Turnover

Annual turnover range	Percentage (%)	Number (#)
<=R1,000 000	26.7	32
R1,000 000 to R4,999 999	22.5	27
R5,000 000 to R9,999 999	9.2	11
R10,000 000 to R14,000 000	11.7	14
>=R15,000 000	7.5	9
No response	22.5	27
Total	**100**	**120**

Net Profit
There is a big difference between annual turnover and net profit. Again, for this study, it is highly important to look at whether HIV/AIDS is really affecting the bottom line (profit) of the firms in the sample. For this reason, Section 8 (where this is discussed in more detail) also tracks the changes in terms of effect of HIV/AIDS on the profit comparatively between Phase one and two.

5.5. Client Profile Analysis

Getting insight into how the impact of HIV/AIDS on markets can affect a firm is an important strategic decision for companies. It is not simple to measure however because it is dependent on the profile of a firm's clients. On a macro-level it is estimated that highly infected countries' gross domestic product growth rates could be reduced by between 0,6% and 14% per annum.[8] On a micro-level, much analysis and understanding is still needed on the impact of the disease on customers. One South African company, the JD Group, has already undertaken an assessment of the impact of HIV/AIDS on its clients.[9] This assessment forecast shrinking markets and altered spending patterns as customers spend more disposable income on AIDS-related treatment. Therefore because customers are the life-blood of any business, cognisance must be taken of the potential impact of HIV/AIDS on markets.

This section does not discuss this in detail but only profiles the sample in terms of firms' predisposition to being impacted depending on the nature of their primary clients or markets. In this study, firms were asked to indicate who their primary clients were, and the range of choices from which firms selected included, government, other businesses, and individuals/households, or a combination. Figure 1 shows the spread of the sample's primary clients. Over two thirds of firms

[8] Whiteside A, 'AIDS and the private sector" in *AIDS Always Africa*, 10(5) Feb/March 2000
[9] Whiteside A & Sunter C, AIDS: The Challenge for South Africa. Human & Rousseau Tafelberg, Cape Town 2000. P106-107

indicated that other businesses constituted their "primary" clients, with government/parastatals and households accounting for the rest. From the perspective of planning, and with reference to the JD Group study, the point that should be put across is that firms must not only have a clear picture of who their primary clients and customers are, but also understand the implications of this to their business. Perhaps the key question that any firm regardless of who its primary client is, should be asking, is:

> "What are the possible and specific affects to my firm should my primary clients be affected by HIV/AIDS? In other words, the "possibility" of an affect should be the first item that a firm considers. Secondly, following on from the possibility of being affected, firms need to consider "how" they could be possibly affected, and this would depend on the specific activities that make up their various relationships with other firms".

When we look more specifically at the above question, we should appreciate that the differences between the groups represented below could conjure up different assumptions amongst firms, i.e. certain general statements can be assumed however the issue is more complex and the point is that even with these general statements and assumptions, any given firm should consider the size and representivity of its own customer base. These general statements and assumptions can include the relatively lower risk of having government/parastatal organisations as your primary client, given its responsibility (in theory) to not only support, but also to put into practice themselves, measures that inform their own staff on issues of national significance. One could also assume that for private businesses, the absence of a mandate such as that for the government could mean that there is greater risk of assuming that firms would be undertaking awareness, prevention and/or treatment measures when other priorities taken precedence.

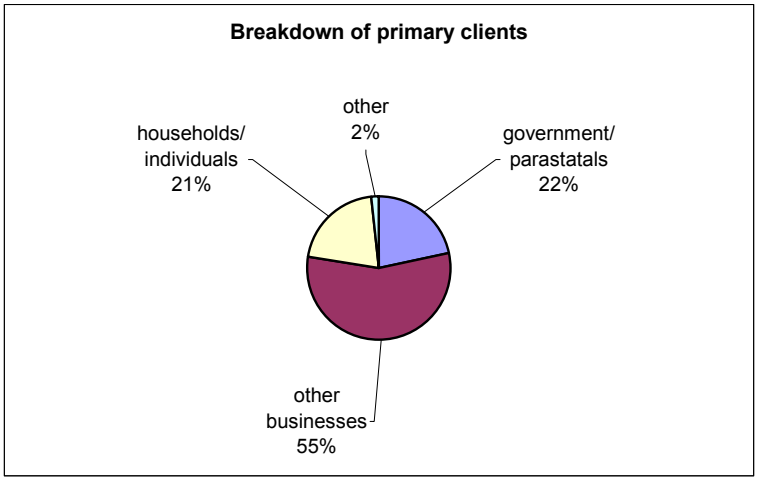


Figure 1: Breakdown of Primary Clients

6. HIV/AIDS FINDINGS

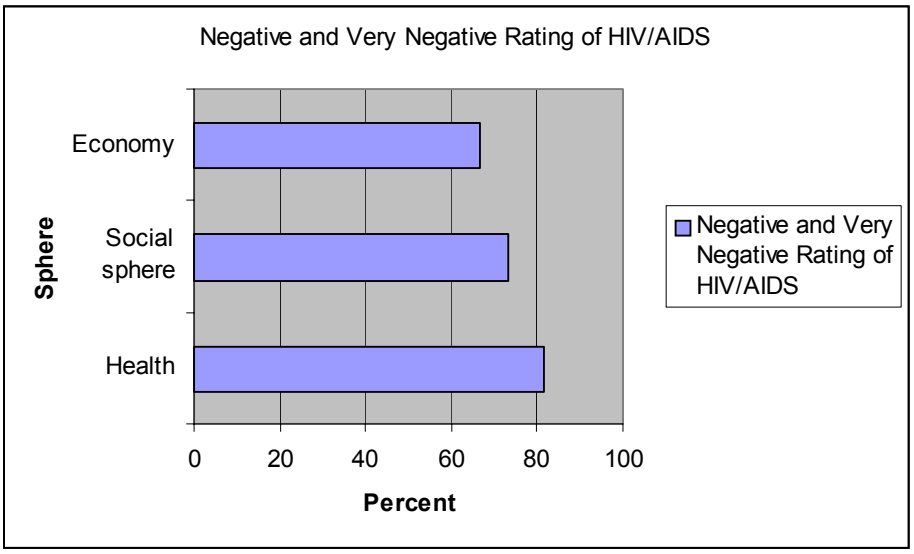
The following section contains our findings related to the Phase two questionnaire. As indicated in the introduction to this report, the project team considered the information obtained in Phase one, the way in which it was obtained via the questions posed, and the implications for the re-design of the Phase two questionnaire in order to refine the data gathering process. Where the results of Phase two as presented below have been influenced by the re-design of questions, this will be indicated. In Section eight, we will discuss the major comparative variables and findings between Phases one and two.

6.1 HIV/AIDS Perceptions

We asked owner/managers about their perceptions of HIV/AIDS on various spheres of society. We chose to ask the question differently this year as opposed to a more general question about "what respondents thought about HIV/AIDS" partly because of the overwhelming number of respondents (97%) who did view HIV/AIDS as a serious problem ("real killer disease") in Phase one. We felt that the next step was to ask respondents about their view of HIV/AIDS as it related to particular spheres of South African society, namely "health", "the economy" and the "social" sphere, which could be considered based on observation in public forms of communication such as the media in particular, the primary areas of society within which HIV/AIDS has been discussed and deliberated.

As figure 2 below illustrates, we asked how each respondent would rate the effect of HIV/AIDS on these spheres on a scale from "very little effect" through to "neutral" to "very negative affect". The first thing that was apparent is that in each sphere there were a greater proportion of respondents falling within the "negative" to "very negative" categories, illustrating an overall perception of negativity of the impact of HIV/AIDS on all of these spheres. The numbers show over 80% of respondents in the health, nearly 74% in the social sphere, and 67% in the economy categories.

Figure 2: Negative Ratings of HIV/AIDS



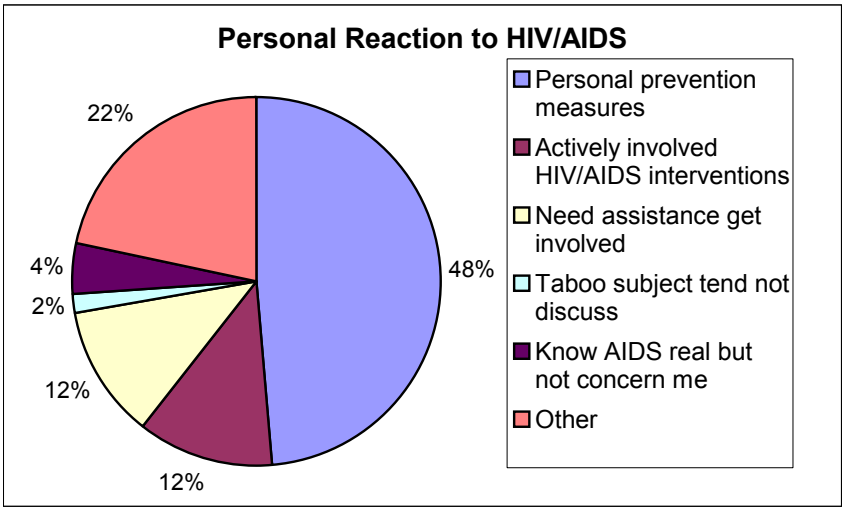
When we consider these numbers across spheres, we see the greatest proportion of respondents having a negative and very negative view of the impact of HIV/AIDS in the health category, with the economy receiving the least among the three. When one considers the arenas in which HIV/AIDS has been discussed in the public domain in South Africa, i.e. particularly the media, publicly debated amongst governmental and non-governmental representatives, as well as amongst those supporting HIV/AIDS research and programmes, it is clear that the health-related aspects of

HIV/AIDS have received a significant portion of attention, i.e. drugs and the treatment of HIV/AIDS sufferers in particular. The effect of HIV/AIDS on society including children and orphans, as well as on communities has also received a great deal of attention. In contrast, the impact of HIV/AIDS on the economy has not been reported in as much quantity and clarity for the average citizen, many of who are SME owner/managers. Working on the assumption that if they were more aware of information on HIV/AIDS directed at business and small business, they would obtain it, we asked respondents if they had obtained information on HIV/AIDS directed at SMEs. Only 10% responded that they had. This could either be viewed as lack of initiative on the part of SMEs to actively seek out such information, or the fact that this type of information just doesn't exist or is poorly marketed.

6.2 Personal response versus business actions taken

When we looked at the personal response to HIV/AIDS versus business interventions/actions taken, we were interested to learn about owner/manager actions taken with respect to HIV/AIDS, on an individual/personal level, and at firm level. The reason for this question was that in our Phase one findings we found a large gap between the personal reaction and actions taken by owner/managers to HIV/AIDS, and actions taken at firm level. Again this could be the result of either a lack of, or poor, marketing of information directed at the impact of HIV/AIDS on the economy and business. When firm respondents were asked what has been their individual/personal reaction to the message about HIV/AIDS, over 60% were either taking personal prevention measures (48.7% or 58 firms) or actively involved in HIV/AIDS interventions (11.8%). Further to this, 11.8% said they needed assistance to get involved in HIV/AIDS interventions. Of the 22% who said "other", 20% were "not applicable" (non respondents I think), and 10% were "horrified by the effect on the economically active population".

Figure 3: Personal Reaction to HIV/AIDS

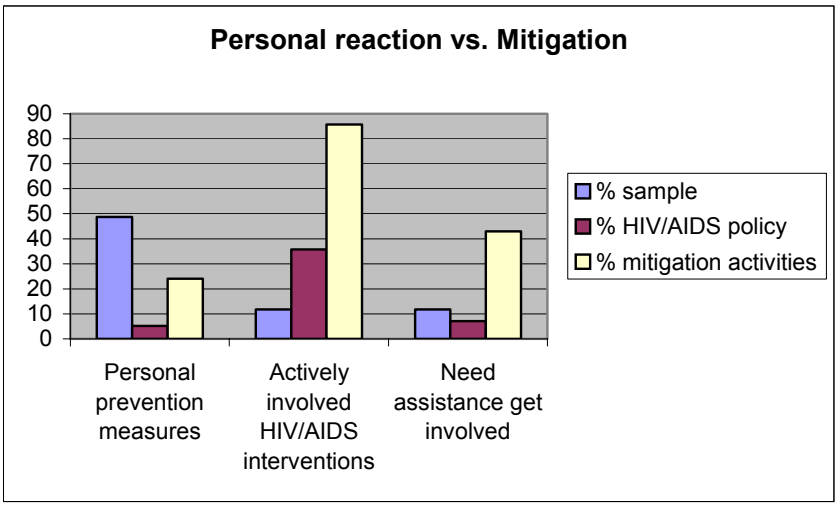


When we looked at firm-level interventions over our entire sample, we found that nearly 12% of firms said they either had or were in the process of developing an HIV/AIDS policy, with 34% saying they were engaging in HIV/AIDS workplace activities. When we cross-referenced the most frequent types of personal reaction with mitigation activities, we found that those firm respondents who were actively involved in HIV/AIDS interventions were also those who were most active at firm level. Figure 4, also shows that mitigation activities were more frequent when compared with HIV/AIDS policies. What could be the reasons for a comparative lack of HIV/AIDS policies amongst the entire sample versus mitigation activities? One must first of all consider the range and variety of types of HIV/AIDS activities that are possible from the very informal and irregular discussions to

literature and materials to more formal and regular workplace programmes/discussions/workshops, categories as identified in our Phase one report.

We found that the most common type of mitigation activities cited in Phase one were irregular and informal discussions, which represented 20% of the total of 33% of overall mitigation activities. People tend to think of "policies" in general as being items that typically require more organised attention, research, and time to prepare. The value of policies is that they can serve as an effective guide to designing and acquiring well-thought-out and relevant workplace activities. We have already seen that one of the major problems that SME owner/managers have is lack of time when it comes to implementing HIV/AIDS workplace activities. We discuss in more detail findings related to HIV/AIDS policies and mitigation activities later in Section 7.

Figure 4: Personal Reaction vs. Mitigation



6.3 HIV/AIDS and the Effects on Firms

With the background provided in sections 7.1 and 7.2, the picture that is emerging is one of "business level under-development" of HIV/AIDS prevention and management with a greater proportion of respondents being more actively involved in personal prevention than at business-level prevention, and comparatively more mitigation activities than policies. We wished to investigate this phenomenon further however by inquiring into how owner/managers thought HIV/AIDS could affect their businesses in order to assess, given the above, whether they even thought about HIV/AIDS, and if so, in what descriptive terms? We in fact received a great range of feedback from this question and the most prominent responses are listed in Table 5.

Table 5: Perceptions on how HIV/AIDS can affect a Business

Response	N=118	% Of Total
Decreased productivity/production loss/can't meet deadlines	51	43%
Decrease in staff morale/psychological affect on other staff/tension in work environment	22	19%
Loss of skilled staff/skills	21	18%
Increase in replacement costs and time for finding and training	15	13%

permanent replacements		
OTHER	9	7%

The most frequently cited response by far was a concern for a decrease in productivity, production losses and not being able to meet deadlines given the effect of AIDS on employees. This was followed by the effect on staff morale and a negative effect on inter-staff relations given HIV infected employees. 18% of firms also expressed concern for the loss of skilled staff and skills within their operations followed by 13% expressing worry over the costs associated with finding replacement employees. On the whole the common themes that SME owner/managers appeared to be expressing, was related to maintaining production levels, either via the direct ability of their operations to maintain production levels, and also concern for maintaining the indirect factors of maintaining production levels such as staff cohesion, skills maintenance and the "replaceability" of staff.

6.4 Susceptibility and Vulnerability

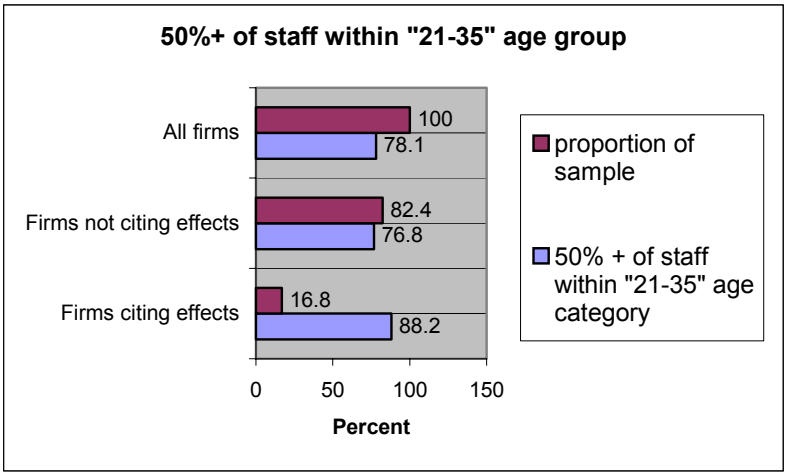
As in Phase one, we included questions that looked at indicators of "susceptibility" and "vulnerability" with respect to the management of HIV/AIDS at firm level[10]. Our indicators of susceptibility included age segmentation, region, sector, as well as gender, marital status, migrant worker composition and frequent business related travel. Our indicators of vulnerability included HIV/AIDS policy in place and mitigation activities. As indicated in Section six, we wanted to stress the importance of subjecting our entire sample to indicators of susceptibility and vulnerability because on the whole it was more important to say that it wasn't good enough to simply try to identify and scrutinise only those firms that had cited costs, when it was probable and realistic to suggest that any of the firms in our sample, all things being equal, could be affected by HIV/AIDS, because as with individuals, the disease is indiscriminate. It was therefore necessary for SME planning as well as for the design of SME support activities to point out how important risk profiling was for "planning" for an HIV/AIDS impact, rather than just "managing" an impact after it was identified.

6.5 Affected and non-affected firms by proportion of "risky" age segment

By "risky" age segment, and as indicated in section six, we refer to the "21-35" band. From the point of view of risk and susceptibility profiling, we wanted to compare firms that had cited affects with those that did not, in terms of the proportion of their employees falling within the "21-35" age band. As indicated in Section six, a common variable in demographic and economics-related HIV/AIDS research is to look at the prevalence of infection amongst different age bands. What we found in Phase one was that 93% of the firms citing effects had 50% and more of their staff falling within the "21-35" age band. This was compared with 78% of the firms not citing effects. The point here is not so much the comparison between the two as it is to say that regardless of effects, both groups had very high proportions of their staff falling within this particularly high age risk band. When we ran the same comparison between affected and non-affected firms according to the proportion of their staff falling between the "21-35" age group this year, we found the following:

[10] Susceptibility refers to a predisposition to infection, and vulnerability refers to the features of a social or economic entity that make it more or less likely that the excess mortality and morbidity associated with the disease will adversely impact the entity. See Barnett T & A Whiteside, *Guidelines for Studies of the Social and Economic Impact of HIV/AIDS*. UNAIDS, Geneva, 2000, p. 9 and 10.

Figure 5: No. of Staff in "21 – 35" age group

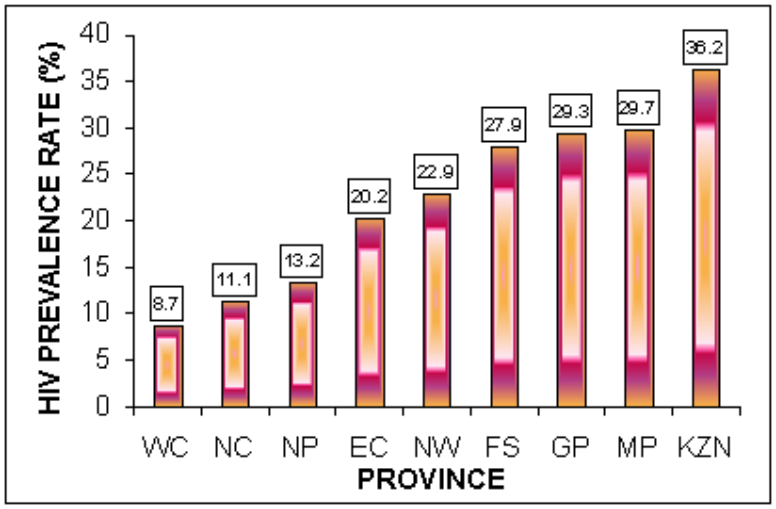


Of all firms in the sample, 78.1% had "50% or more" of their staff within the "21-35" or "risk" age band. When we distinguished firms citing effects from those not citing effects, we again found very high proportions of employees falling within this risk band for both groups. The point is that when considering actions to be taken, the firm should be viewed as a sort of microcosm of society, and if we then consider prevalence rates among different age groups in society and compare it back to the age profile of one's staff, the risks of having an HIV infected employee in any firm, regardless of costs cited, and given such an age profile, can then be observed.

6.6 Effects cited for firms per region compared to regional proportion of sample

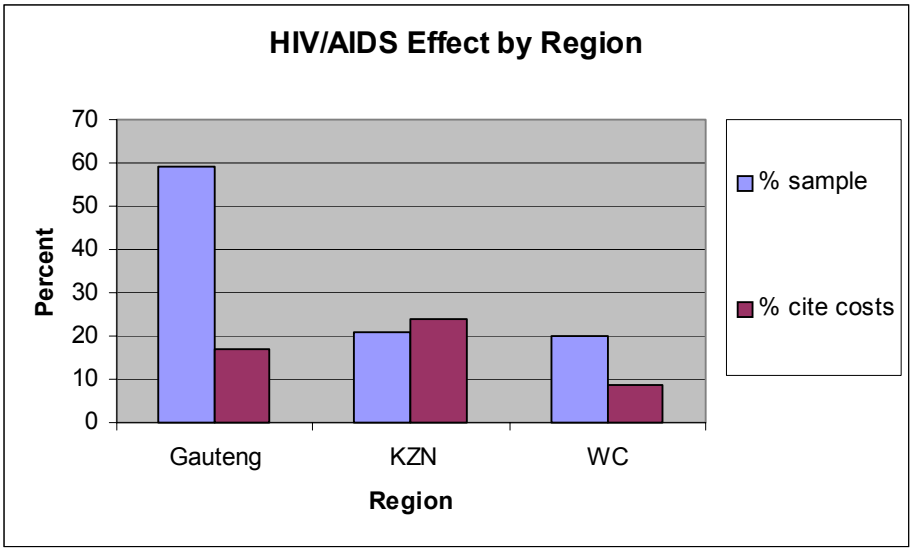
Figure 6 illustrates DATA from the 2000 National HIV and Syphilis Sero-Prevalence Survey of women attending Public Antenatal Clinics in South Africa, published by the Department of Health. The figure shows KwaZulu-Natal with the highest prevalence rate in the country, compared with the Western Cape representing the lowest, and Gauteng coming just above the national rate. As with Phase one, we decided to look at the effects cited per region against each region's proportion of the total sample in order to investigate whether firms in each of the three regions were citing effects in similar proportions or whether one could that were more or less consistent with demographic prevalence rates. What we found, as in Phase one was a higher proportion of firms in KwaZulu-Natal citing effects compared with its proportion of the sample as compared with firms in the Western Cape and Gauteng.

Figure 6: Prevalence Rate vs Province



Source: Department of Health, South Africa.
http://www.doh.gov.za/docs/reports/2000/hivreport.html

Figure 7: HIV/AIDS Effect by Region



6.7 Costs cited for firms per industry compared to industry proportion of sample

We looked at effects cited by the three most frequent industries in our sample, i.e. manufacturing, general services, finance/professional services. As mentioned in Section six, certain industries have been recognised as being at greater risk of being affected by HIV/AIDS given structural and socio-economic factors such as for example the nature of the transportation industry which contributes to riskier sexual behaviour when employees are away from home on a regular basis, coupled with a sophisticated road infrastructure which has been cited for contributing to the rapid geographical spread of HIV/AIDS. The mining industry has also been identified as particularly susceptible given large numbers of men away from their homes and families living in single sex hostels for prolonged periods of time. As indicated in Section six, due primarily to their size, mining firms and transportation companies were not represented in our sample. However, we do propose

to consider the variable of "labour skill" when looking at the three most frequent industries in our sample.

Figure 8 shows that professional services firms had a slightly higher "effect to proportion of sample" distribution, followed closely by general services firms and manufacturing firms. To derive more meaning from this, we wanted to look at the staffing profile of firms in these industries and particularly at the proportions of semi and unskilled labour. Our hypothesis was that we would likely find greater numbers of firms with greater proportions of semi- and unskilled labour amongst general services firms given such examples as commercial cleaning, catering and security, with manufacturing following close behind given the type of skill sets required in the manufacturing process, followed by lower concentrations of semi- and unskilled staff in finance/professional services firms, given the greater human technical requirements needed for these business. When we ran our analysis we found significant numbers of manufacturing firms between the 60-100% concentrations of semi and unskilled labour, followed by an increasing curve for general services firms which showed greater numbers of these firms as the proportion of semi and unskilled staff also increased. We saw almost the opposite for finance/professional services firms with a curve sloping downwards indicating fewer numbers of these firms as semi and unskilled staff proportions increased.

The context that these findings need to be viewed within was captured by the ING Barings report on the "Economic Impact of AIDS in South Africa", where it was noted that "when examining the infection rates by skills groups, we find that the HIV+ rate of semi and unskilled labour is over three times as high as that of the highly skilled" and that "a similar observation can be made with regard to the number of AIDS deaths by skill category[11] Given this background from the perspective of susceptibility, it could be argued that general services firms and certain manufacturing firms could be more susceptible to the "frequency" of affect, however, as the report also illustrates a rise in the projected AIDS deaths of "skilled" labour through to 2009. In this case, it could be argued that finance/professional services firms could also be susceptible to the "intensity" of affect if less frequent than manufacturing and general services firms, given issues such as skills loss and labour replaceability.

[11] ING Barings. 2000. "Economic Impact of AIDS in South Africa", p. 7

Figure 8: HIV/AIDS Costs by Industry

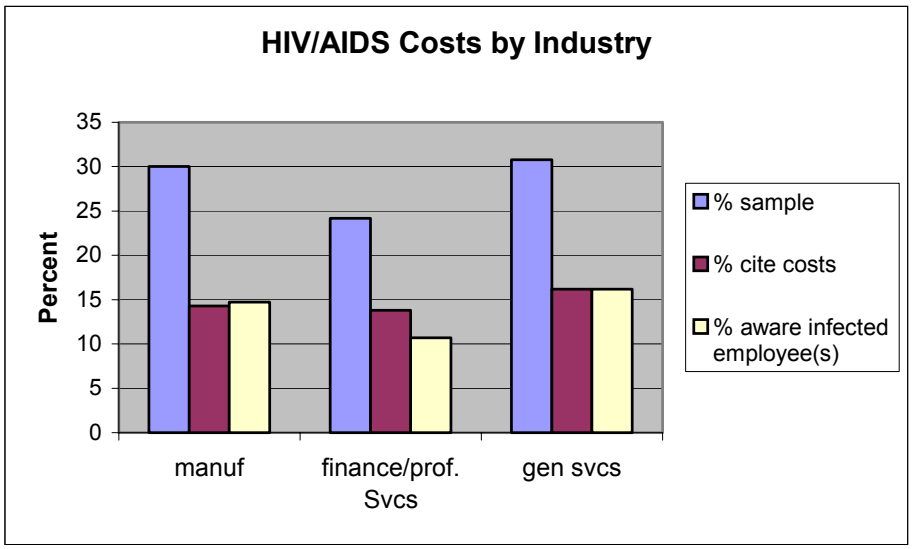
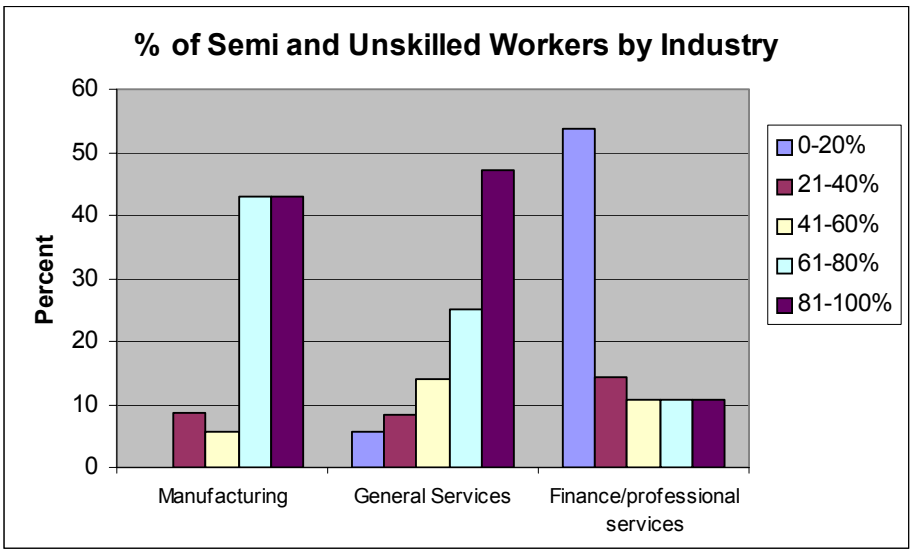


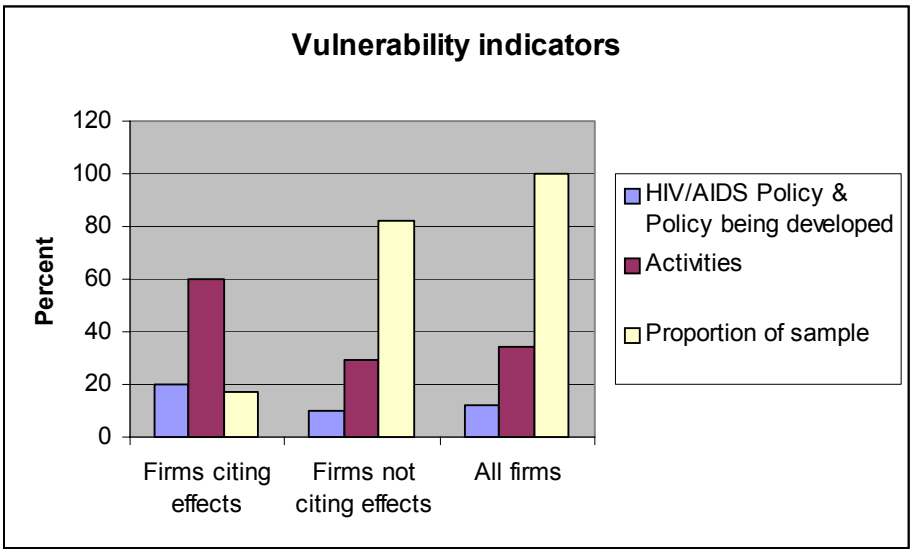
Figure 9 : % of Semi & Unskilled Workers by Industry



6.8 Affected and non-affected firms by HIV/AIDS policies and activities

Vulnerability, of an economic entity is the ability to deal with the adverse impact of HIV/AIDS. In other words, how prepared are SMEs to manage the potentially negative effects of HIV/AIDS? For this we decided to compare firms, citing effects, and those not citing affects, to look at their "mitigation" activities, which included HIV/AIDS policies and HIV/AIDS workplace activities. What we found is a greater proportion of firms citing effects engaged in both workplace activities and with HIV/AIDS policies, measured against their proportion of the sample.

Figure 10: Vulnerability Indicators



If we consider the above in another way however, we can see that the "glass is still half empty" when one just looks at the percentage of firms engaging in mitigation activities overall

6.9 Skills Levels

The issue of skill levels as a factor of susceptibility was very interesting to consider when looking at costs cited, deaths experienced, and awareness of HIV infected individuals, when we divided our sample into increasing proportions by "skilled", and "semi-skilled" and "unskilled", for full-time staff in 2001. The results are shown in figures 11 and 12 below. In figure 11, we observed that there were more firms citing firm-level effects, deaths, and awareness of HIV infected employees, the higher the proportions of semi- and unskilled staff as a factor of total staff. When we looked at skilled staff only, we found that the opposite was observed, that there was a decline in the number of firms citing firm-level effects, deaths, and awareness of infected employees with the increase in skilled staff as a proportion of the whole.

Moreover, the report "Impending Catastrophe Revisited: an update on the HIV/AIDS Epidemic in South Africa" notes that "…the actual impact [of HIV/AIDS] will depend on the ease with which employees can be substituted. For a high skill, labour-intensive industry it will be very costly to train replacement staff…"So the concern runs deeper than just skills proportions but also involves questions such as recruitment and replacement costs, i.e. relative cost of having a "skilled" employee affected versus a "less skilled" employee and the cost implications in terms of production, money and time. The point that should be made is that SMEs and the organisations that are either currently supporting them or have the capacity and willingness to do so need to look at their staff composition by skill set and factor the implications into appropriate HIV/AIDS workplace interventions.

Figure 11: Semi- and Unskilled Staff vs. HIV/AIDS Effects

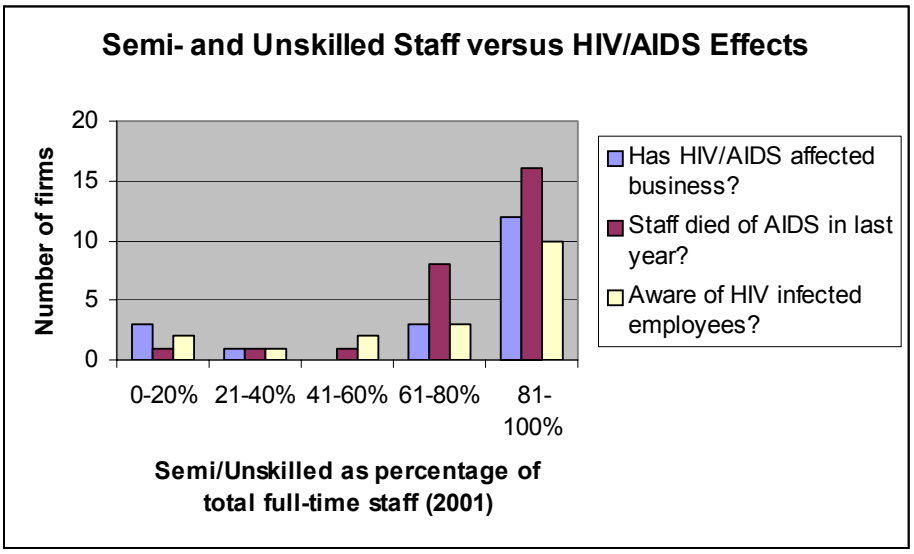
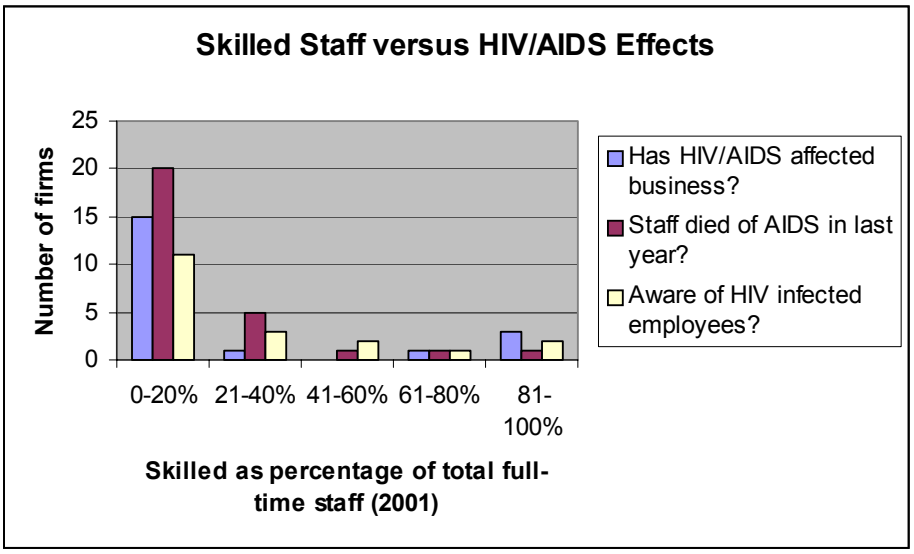


Figure 12: Skilled Staff vs HIV/AIDS Effects



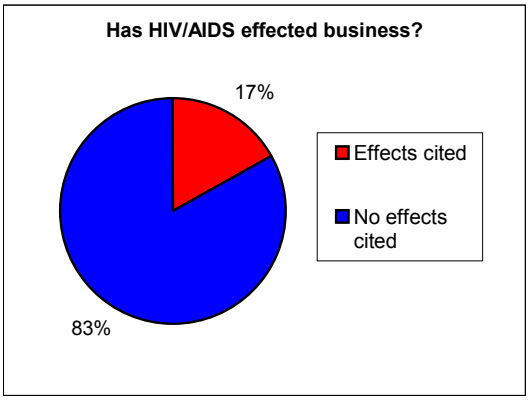
6.10 Costs due to HIV/AIDS

Figure 13 illustrates that 17% of firms indicated that they had been affected by HIV/AIDS, as compared with 25% in the Phase one survey. It bears mentioning that the way in which we asked this question in both years could have influenced the finding. We phrased:

- Phase one "Do you think HIV/AIDS is a problem to your organisation, or is having an effect on the performance of your staff?"
- Phase two "Has HIV/AIDS had an effect on your business?"

We realised from our Phase one experience that asking the question in a more direct and closed fashion was more likely to focus the respondent's attention and mind on providing a response free from interpretation.

Figure 13: Has HIV/AIDS Effected Business



6.10.1 Direct and Indirect Costs

As indicated in Phase one, many studies on the economic impact of HIV/AIDS distinguish between "direct" and "indirect" costs. Making the distinction usually stems from the nature of the disease, whose effects come via varying forms as well as levels of severity, and therefore have accompanying costs to society on macro and micro levels as well as at business and household levels to name just two. A study of the Economic Impact of Aids on South African Business (large companies) by the Centre for International Health at Boston University defined direct costs as benefits payments, recruitment and training expenditure, overtime and casual wages, and indirect costs as reduced on-the-job productivity, increased absenteeism, and supervisory time. This definition is applied to individual employees with HIV/AIDS.

We also referred to Bollinger and Stover's[12] matrix of costs that looked at the issue from the perspective of "factors leading to increased expenditure" and "factors leading to decreased revenue". Their matrix adds more depth to the issue of costs, if one looks at the grouping of variables used in the following table, one can observe that in simplified terms "direct costs=increased expenditure" and "indirect costs=decreased revenue". This issue is however more complicated than this and we prefer to view the cost debate in terms of "out of pocket expenses", i.e. direct costs as being physical out of pocket expenses.

Table 6: Factors leading to increased / decreased expenditure

Factors leading to Increased Expenditure	Factors leading to Decreased Revenue
Health care costs	Absenteeism due to illness
Burial fees	Time off to attend funerals
Training and recruitment	Time spent on training
	Labour turnover

With guidance from the above, and for the purposes of this Phase, "direct" and "indirect" costs were defined according to the following criteria:

[12] Bollinger, L and Stover, J. 1999. "The Economic Impact of AIDS". The Futures Group International

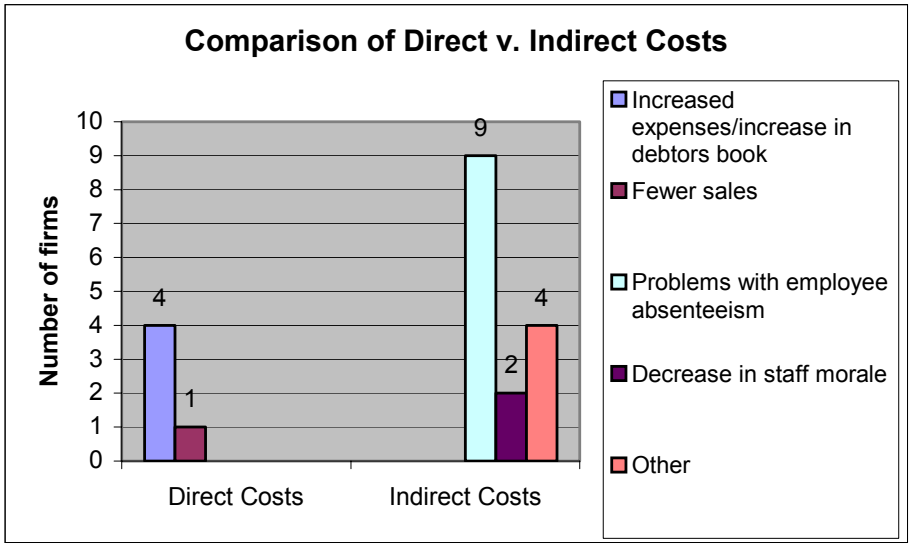
Direct costs: increased expenses and increase in debtors book, fewer sales, lost clients to AIDS. We also looked at firm expenditure on recruitment and training but these could not be viewed as AIDS-related costs to the firm, given the minimal amounts of expenditure being directed at recruitment and training found in Phase one. Our intention in Phase two was rather to look at a firm's total expenditure profile and proportionally aggregate the labour related categories to look at question from the perspective of risk (see section 7.7).

Indirect costs: increased staff turnover, shortage of skilled labour, problems with absenteeism, decrease in staff morale, effect on market.

As in Phase one we saw a greater number of firms citing indirect costs versus direct costs. We did provide different categories in Phase two based on what we learned in Phase one. For example, we decided to provide broader direct cost categories including "increased expenses" and "increase in debtors book" because we felt that expecting SMEs to indicate whether their pension scheme for example was being impacted by HIV/AIDS could be exceedingly difficult. Secondly we decided to simplify the response for absenteeism to just read "problems with absenteeism", be they related to illness or other factors due to the difficult of owner/managers identifying the true reason for an absence without notification. Finally we took out reduced productivity due again to the difficulty in measuring the certainty of the role and level of influence of HIV/AIDS on this.

The most significant observable indirect cost cited in Phase two was "problems with employee absenteeism". Four firms indicated increased expenses due to HIV/AIDS and another four mention "other". The "other" category included "increased absenteeism and expenses", "the loss of trainees/clients to AIDS", "increased expenses and staff turnover", and "loss of a staff member". When we asked all firms what the primary reason for employee absenteeism had been in the last year, 50% indicated said "health/illness" with the next largest category being just over 9% who mentioned "family responsibilities/problems". We cannot say for certain, or indeed with much accuracy, what caused the absenteeism identified as problems by some firms, but from the standpoint of risk, every firm should factor HIV/AIDS mitigation into their particular experiences with absenteeism and sick leaves. See figure 14.

Figure 14: Comparison of Direct vs. Indirect Costs

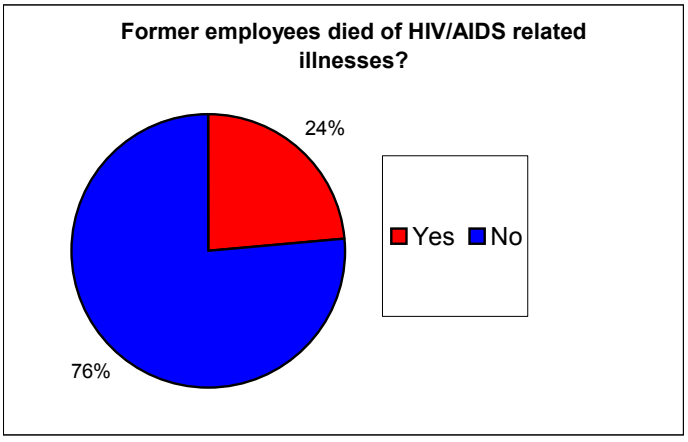


*N=19 firms responding of 20 total citing costs; One firm cited two costs (Increased expenses & problems with absenteeism)

6.10.2 AIDS-related Deaths

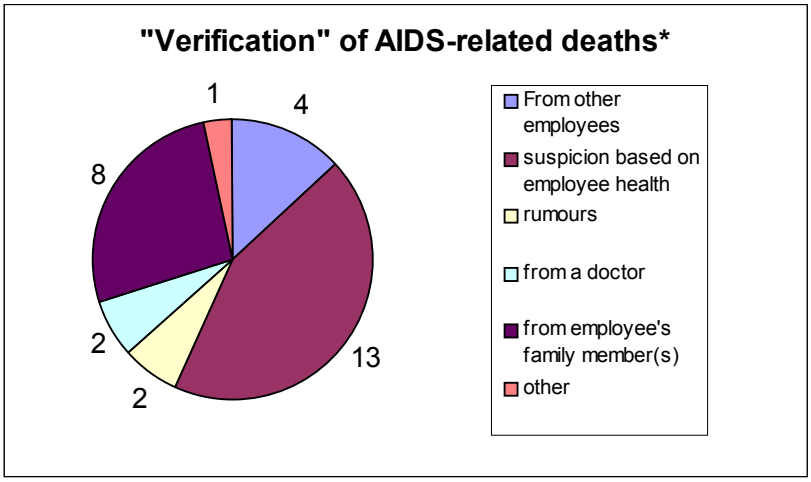
As figure 15 illustrates, 24% of our sample indicated that former employees had died of HIV/AIDS related illnesses. Given the uncertainty and confidentiality of knowing for certain that HIV/AIDS caused the opportunistic infections that can lead to eventual death, we asked owner/managers how they confirmed that the deaths were attributed to HIV/AIDS.

Figure 15: Employee deaths through HIV/AIDS



When we asked those firms who had indicated that former employees had died of AIDS related illnesses, how they could verify this, 13 of the 28 firms that confirmed AIDS-related deaths had indicated verification based on the "suspicion of employee health" with 8 firms indicating verification by employee family member(s).

Figure 16: Verification of AIDS-related deaths



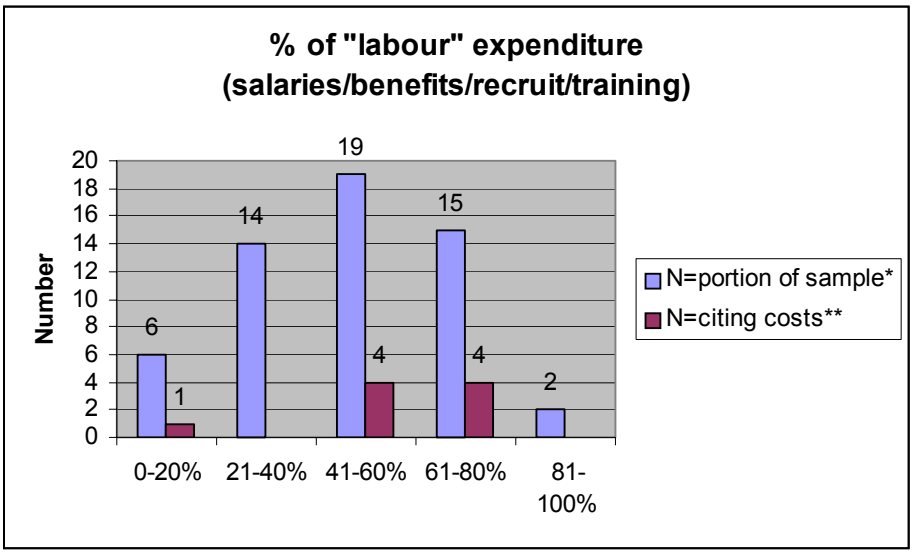
*N=28 firms in total. 2 firms indicated more than one reason to bring the total responses to "30".

Finally, we wanted to look at what, if anything, firms that had experienced deaths due to HIV/AIDS-related illnesses were doing in the way of mitigation. We found that 65.3% of firms that had cited deaths related to HIV/AIDS were engaging in mitigation activities.

6.11 Expenditure Proportion

We asked firms about the composition of their total expenditure, broken into salaries, benefits, advertising, recruitment, training, and other. The rationale for this was to argue that in theory labour-heavy cost structures are at particular risk of an HIV/AIDS impact because the disease targets a firm's labour directly. We had a relatively low response rate to this question (56 out of 120 firms provided information) given the difficulty many small businesses had in providing us with an accurate profile of their expenditure structure. We feel however that the difficulty of obtaining this kind of information can be surmounted, and indeed should be so, given the importance of the question. One way of doing this is to sensitise SME owner/managers via feedback of this project to the importance of tracking and monitoring this more systematically as part of their planning and budgeting. Figure 17 shows, as a whole, a rise in the number of firms as labour-related expenditure increases where most of the firms fell within the 41-60% band.

Figure 17: % of "labour" expenditure



*N=56; **N=9

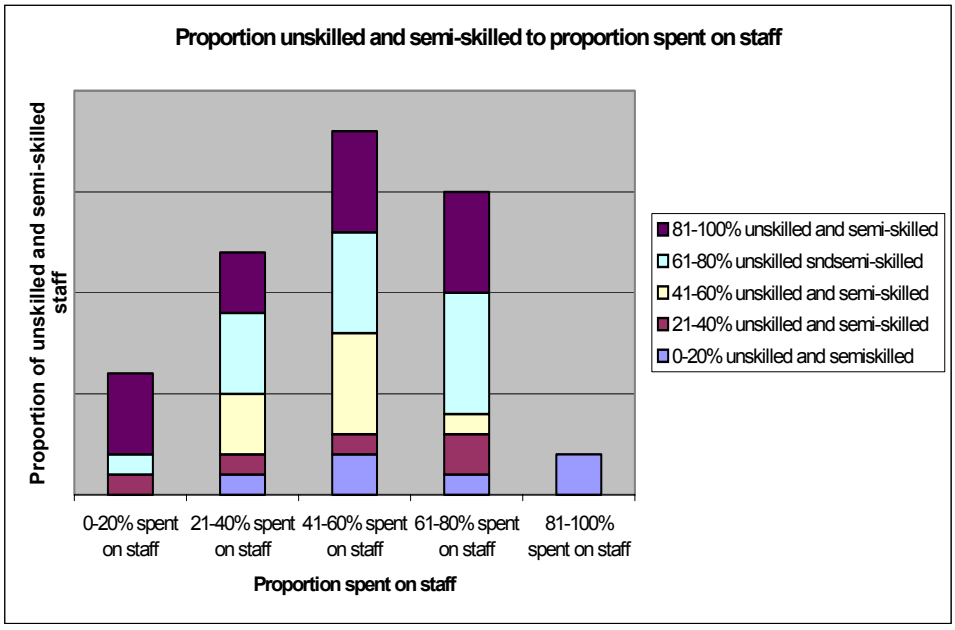


Figure 18: Proportion of unskilled and semi-skilled to proportion spent on staff

*N=53

6.12 Provision of Employee Benefits

When we looked at the frequency of benefits provided to staff, we found that the most frequent were also those required under labour legislation including: paid overtime, funeral/compassionate leave (average of 3 days), and sick leave (average of 13 days). We did however see that close to 40% of firms did have a medical aid plan with over 50% of firms having a pension/provident fund. When we looked more closely at those firms with a medical aid plan, we found that over 46% of these had compulsory plans with more than 62% saying that their plan provided coverage for AIDS-related illnesses. We probed more deeply into those firms with HIV/AIDS coverage, and

found that the 62% with AIDS coverage, when asked what the conditions for coverage were, 44% didn't know and 33% said there were "no" conditions. We should be circumspect about this last response of "no conditions" given the risk involved to medical aid plan service providers of offering plans with coverage for HIV/AIDS, which in general and apart from just HIV/AIDS, involve specific conditions and provisions according to coverage.

Figure 19: Benefits Provided

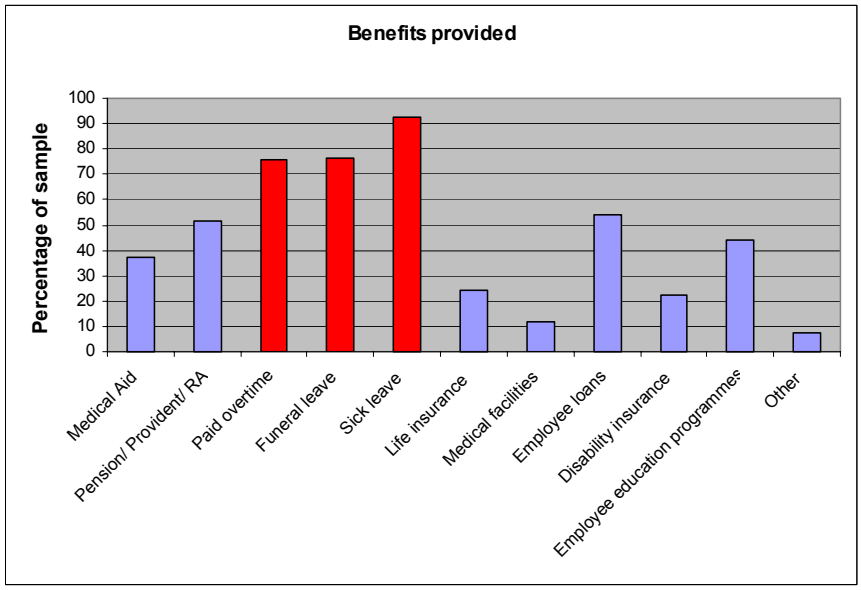
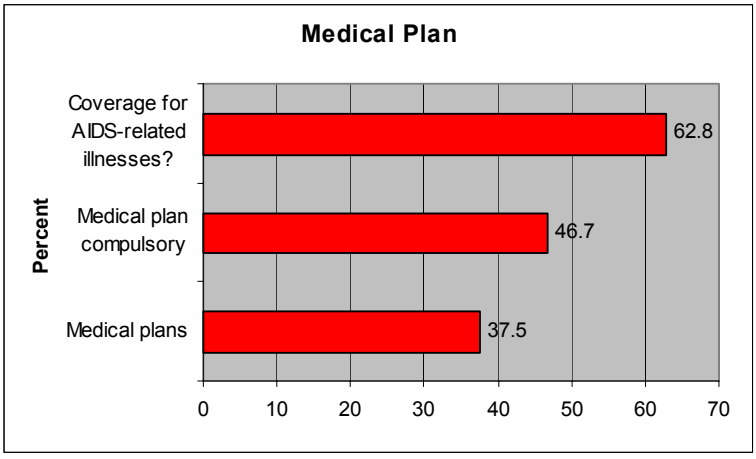


Figure 20: Medical Plan

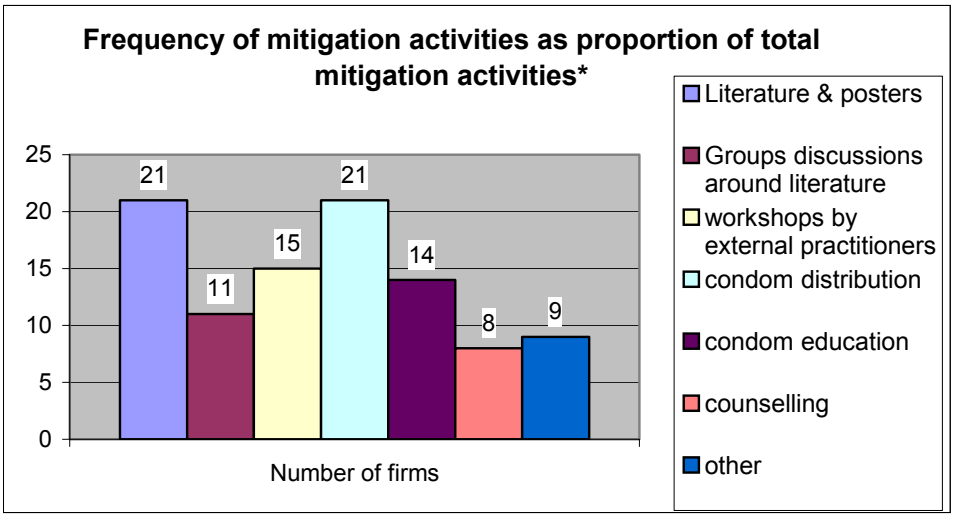


6.13 Mitigation Activities

We wanted to discuss in more depth the issue of mitigation in order to observe what firms are doing, why they are doing it, and how mitigation can be improved. We have already seen that 34% of the sample, or 41 firms, are engaging in mitigation activities. We then asked firms about the specific types of activities they were engaging in and posed the question in such a way as to pick up multiple types of activities. The results are shown in Figure 21. We found that the availability

and distribution of materials (e.g. literature/posters and condoms) were the most common type of mitigation activity engaged in, followed encouragingly, by condom education and workshops by external individuals, which we could term more formal in terms of being more "active". We use the word "encouraging" because in Phase one "irregular and informal discussions" formed by far the largest proportion of mitigation activities.

Figure 21: Frequency of mitigation activities



* Count represents only those firms engaging in mitigation activities and also represents numbers of firms citing provisions where more than one provision could be chosen.

We were interested to look at size of firm versus engagement in mitigation activities including HIV/AIDS policies. When we looked at mitigation activities, we found a greater proportion of firms within the larger size groups (25 staff and above) to be engaging in mitigation activities as compared to their percentage of the sample respectively. We also observed the same for HIV/AIDS policies.

Figure 22: Mitigation by firm size

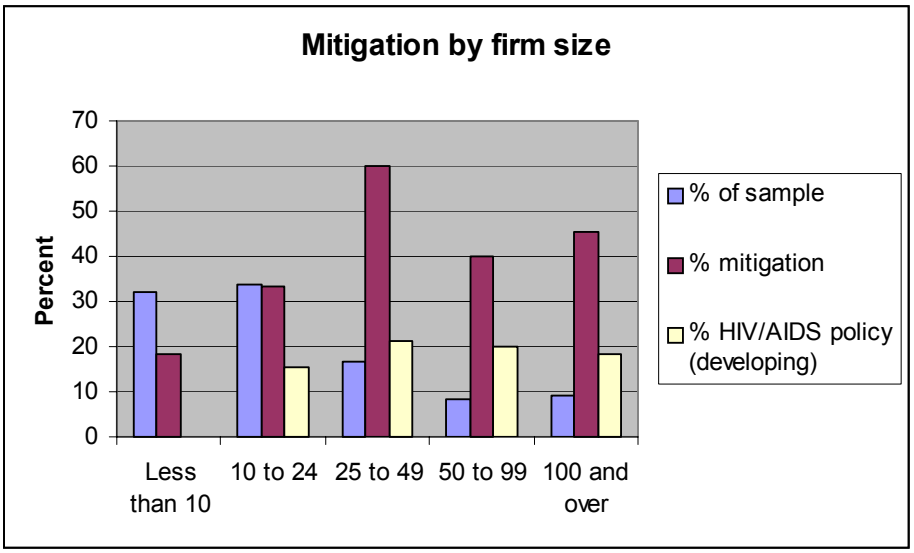
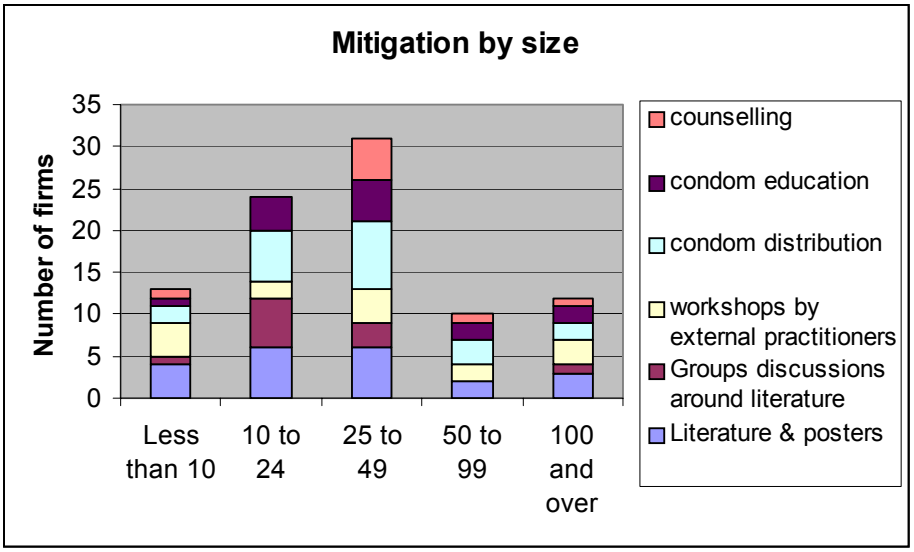


Figure 23 makes a comparison of types of mitigation activities across the size categories. The first and perhaps most obvious picture that emerges is the great variety of mitigation activities happening across all size categories. Perhaps the least formal of all activities (provision of literature and materials) appears more prominently in smaller firms, but encouragingly so do workshops by external practitioners that are visible in firms with staff of ten or less.

Figure 23: Mitigation by size



N=41 firms in total engaging in mitigation activities.

When we asked those firms that did not engage in HIV/AIDS mitigation activities (65.5% of total) why they did not, they provided the following responses:

Table 7: Responses of firms as to why they do not engage in mitigation activities

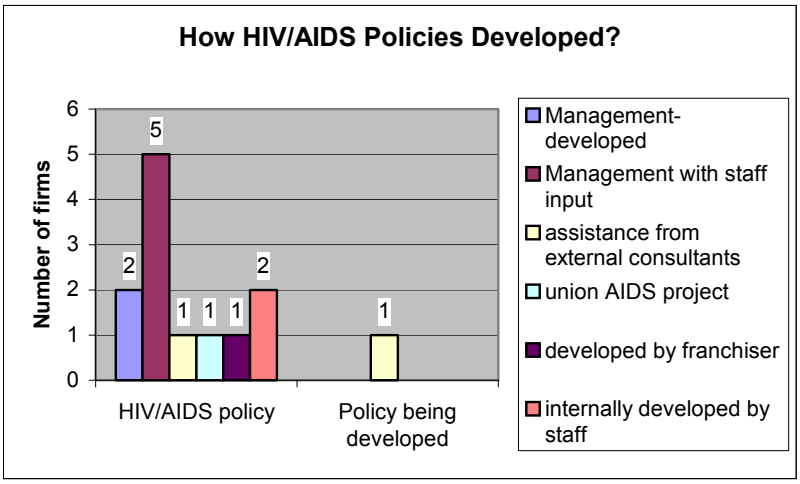
Response	N=78	% Of Total
"Haven't been affected yet/not a problem"	24	30.8%
"Don't know enough to start programme/need assistance"	10	12.8%
"No reasons, haven't thought about it"	8	10.3%
"Time constraint"	6	7.7%
"Trust employees aware/educated, especially skilled staff"	4	5.1%
Other	26	33.3%

The largest group of respondents indicated that they did not engage in mitigation activities because they had not yet been affected, and it was thus not viewed as a problem.

When we looked more closely at the twelve firms that did have existing HIV/AIDS polices, we found that nine firms had policies designed via a combination of management and staff inputs, with the majority being designed by management with staff input. Only one company had sought the assistance of an external service provider. The significant way of looking at this question is the utility of "off the shelf-purchased" HIV/AIDS policies versus internally-developed policies, i.e. the participatory process of design and engaging staff in the design of a policy addressing such a

delicate and difficult issue. It can be viewed as encouraging that more of the firms with existing policies have gone the route of internally developed policies. A lesson that can be learned for future surveys would be to interrogate further what information firms with internally developed policies referred to and why. But this is of relatively little importance within the bigger picture given that only 12% of our sample had or were developing HIV/AIDS policies.

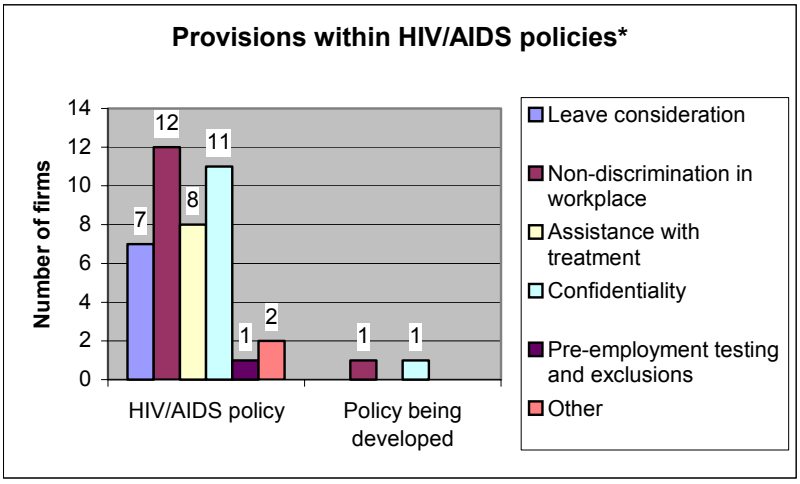
Figure 24: How were HIV/AIDS Policies developed



N=13 firms in total: 12 firms with existing HIV/AIDS policies; 1 firm with policy being developed.

When we looked at the most frequent types of provisions that firms included in their HIV/AIDS policies, the common theme was ensuring that employees were protected by confidentiality and non-discrimination clauses. The observation is that the frequency spread of the provisions below suggests that firms in our sample appreciate the "minimum" legislative requirements as well as social aspects of managing an HIV infected employee within the businesses. We use the word "minimum" because firms could, depending upon the availability of time and financial resources include more firm specific provisions such as leave consideration, assistance with treatment (if in a monetary form such as costs medication) or other forms of monetary assistance, i.e. funeral expenses.

Figure 25: Provisions within HIV/AID policies



*Count represents only those firms with existing or developing HIV/AIDS policies and represents numbers of firms citing provisions where more than one provision could be chosen.

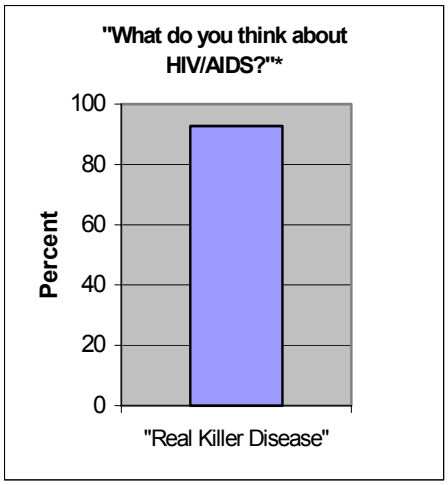
7. COMPARATIVE ANALYSIS

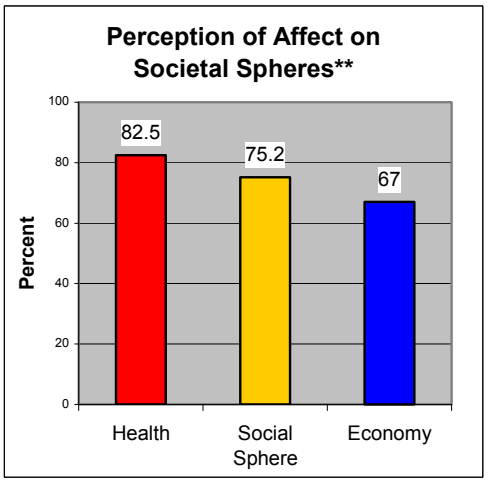
This section compares the sample of firms which participated in both Phases one and two. The aim of the comparative analysis is to track potential changes that have occurred over a two-year period on specific variables such as general perceptions on HIV/AIDS, individual/personal versus business responses to the impact of HIV/AIDS, the costs associated with HIV/AIDS as cited including the frequency of the various types of indirect costs, the incidence of prevalence of HIV/AIDS at firm level (includes levels of absenteeism), HIV/AIDS related deaths being reported, types of mitigation activities being employed by firms, as well as HIV workplace policies. All of these findings came out very strongly in Phase one, and their importance was therefore highlighted in the second Phase. It is important to note that 97 firms or 81% of the sample that participated in both Phases form the basis of this comparison.

7.1 General HIV/AID perceptions

In Phase one we asked owner/managers of SMEs about their perception of HIV/AIDS. The question was quite prescriptive in nature[13]and allowed respondents to choose from a menu of available options provided in the survey instrument. An overwhelming percentage of respondents, 92%, indicated that HIV/AIDS was a “real killer disease”.

Figure 26: Owner / Manager Perceptions





*N=97 **N=96

One of the lessons we learned in Phase one was not to be too prescriptive in posing a perceptive question so as not to prompt or lead respondents to a particular opinion of HIV/AIDS. For this reason, we decided in Phase two to ask respondents to rate the “effect” of HIV/AIDS on different spheres of society including Health, the Social, and the Economy. We felt that this question was suitable and appropriate in that it did not prescribe particular opinions/views of the disease whilst at

[13] We asked the respondents “What do you think about HIV/AIDS?” We also provided options from which the respondents selected, e.g.”HIV/AIDS is a killer disease”, “it is a myth” and so on.

the same time addressing the prominence of the issue within the context of major spheres of South African society. It also allowed us to compare how SME respondents considered the impact of the disease on the economy versus the Health and Societal spheres. The rating scale asked respondents to rate the effect of HIV/AIDS on a scale from (1-5) with 1 indicating "very little effect" and 5 indicating "very negative effect". To this question, over 80% of firms indicated HIV/AIDS had a negative, or very negative effect on Health, with 75% citing the same for the Social Sphere and 67% for the economy.

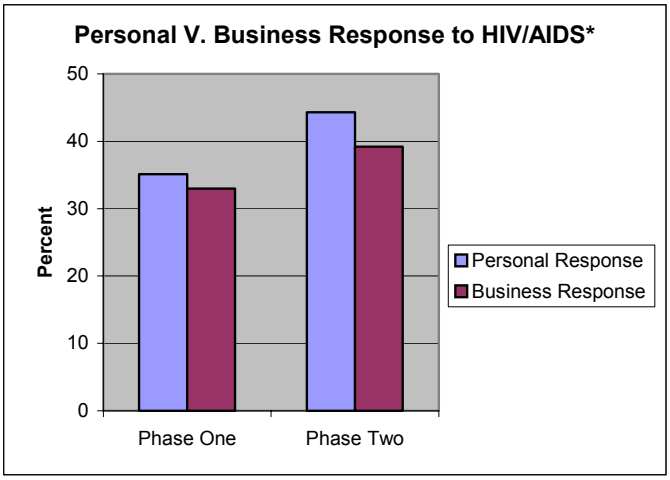
Within the Health sphere, some respondents highlighted a general increase in morbidity of many South Africans, whilst some of the respondents indicated the pandemic has already negatively impacted on the South African social sphere by citing the increase in orphans as a major problem. As indicated in Section six, HIV/AIDS has received a great deal of attention in the media and much of this has focused on such issues as the provision of drugs, the impact on children and communities, whilst the impact on the economy has received relatively little attention.

Given the change in the question and the reasons therefore, it is not possible to directly compare the responses between the two Phases. What we can comment on however, is the high level of responses viewing HIV/AIDS as a "negative" phenomenon across the spheres, which is in agreement with the Phase one question.

7.2 Personal response to HIV/AIDS versus business response

Our main interest in this section was to learn how owner/managers have responded to HIV/AIDS at an individual/personal level versus their response at firm level. A look at the same firms shows that in Phase one over 35% of firm respondents (120 firms) indicated they were taking personal prevention measures versus 33% who were involved in firm level interventions. In Phase two, we found an increase in the number of firm respondents taking personal prevention measures (44%) versus with 39% engaging in mitigation activities at the firm level. The comparison illustrates a rise in both personal prevention and business prevention in Phase two. Although it is difficult to pinpoint why this is the case, it is reasonable to suggest that the awareness created by the first survey may have at the very least sensitised firms to the relevance of HIV/AIDS impacts at the firm level.

Figure 27: Personal vs. Business response



*N=97

Figure 27 also indicates that owners/mangers are taking "personal safety" more seriously than workplace mitigation activities. We are of the opinion that more firms can still get involved in

workplace mitigation activities if there is increased publicity and visibility of workplace support programmes targeted at SMEs.

7.3 Availability of HIV/AIDS workplace policies

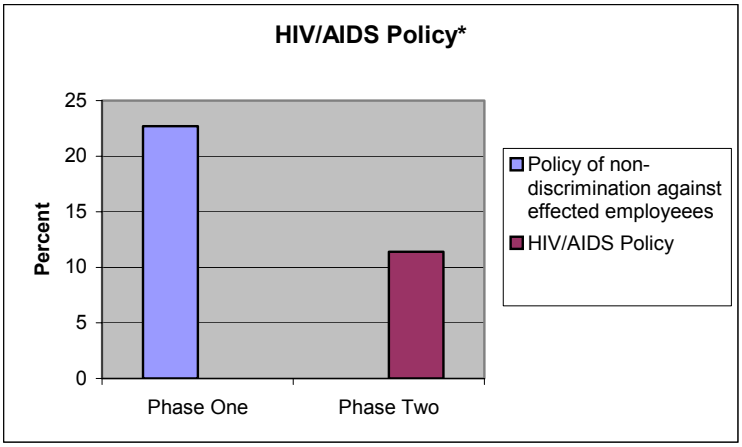
The existence of HIV/AIDS workplace policies is an important signal of how proactive a firm is in "planning" for the impact of the pandemic within their workplaces. The importance of an HIV/AIDS policy cannot be overstated as it gives direction to workplace "planning", versus reaching for ad hoc types of mitigation activities such as literature, posters, condoms, without ensuring that they are accompanied with organised and educative discussions and training. A policy can act as a guideline and coordinating tool that can place mitigation activities within a logical and coordinated strategy. The researchers concede that in Phase one, the question relating to "do firms have an HIV/AIDS policy" was asked in a very indirect and unclear fashion:

- "Do you have a policy that discourages non-discriminatory practices towards HIV infected employees?"

This question was weak in that it did not ask firms directly and clearly whether they had an HIV/AIDS policy, as distinct from any non-discrimination policy including such items as gender, sex, race, which also included HIV infected members of staff. The importance of asking the question more directly can also lead to follow-on question such as "how was the HIV/AIDS policy developed" and "how was the HIV/AIDS policy communicated to staff?" The question was therefore asked more directly in Phase two:

- "Do you have an HIV/AIDS Policy?"

Figure 28: HIV/AIDS Policy



N=97

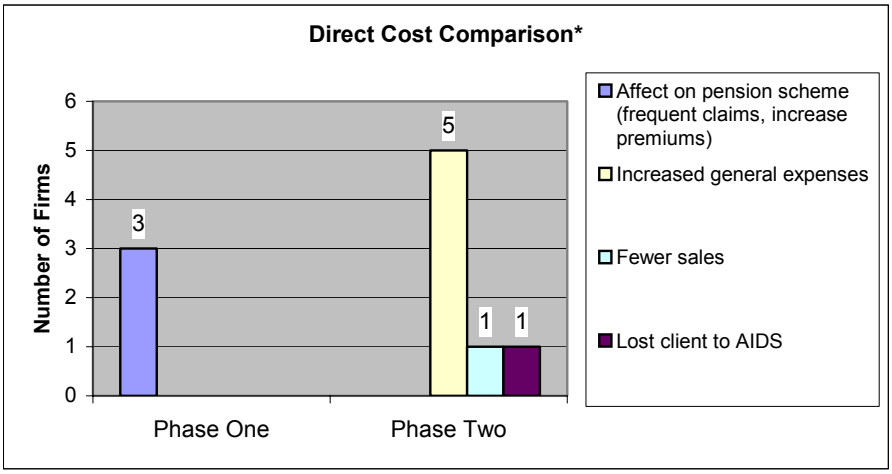
Figure 28 shows that approximately 23% of the firms indicated they had policies of non-discrimination against HIV/AIDS affected employees in Phase one. In Phase two, over 11% of the same firms indicated they had "HIV/AIDS policies". Given the very different manner in which the questions were asked in both Phases, it is very difficult to try to compare the two.

7.4 Direct versus Indirect costs cited

Direct costs

Out of the total sample of 97, only three firms cited direct costs in Phase one. The main cost cited by the three firms was an affect in their pension schemes related to claims/premium rates. An analysis of the same firms in Phase two showed that seven firms cited direct costs related to HIV/AIDS. These costs can be broken down as follows: increased general expenses (medical and other benefits) by 5 firms, fewer sales by 1 firm, and death of a client to AIDS by1 firm. We decided to provide broader direct cost categories including "increased expenses" and "increase in debtors book" versus the more specific categories looking directly at medical/pension and other insurance-related effects, whilst still providing an "other" option to capture these if applicable. We realised that expecting SMEs to indicate whether their pension scheme for example was being impacted by HIV/AIDS could be exceedingly difficult.

Figure 29: Direct Cost Comparison

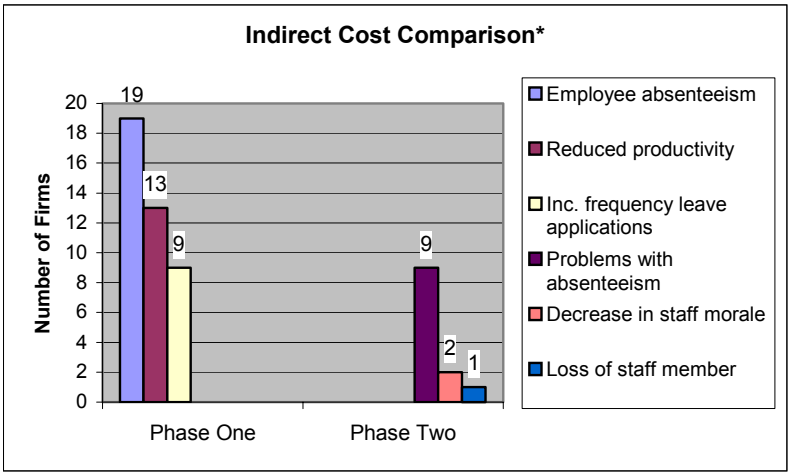


*N=97

Indirect costs

This section attempts to compare the type and most frequently cited indirect costs. As shown in Figure 30, there was a decrease in the number of firms citing indirect costs. It is important to note that we did change the way in which we asked firms "how" they were being affected in Phase two, to again reflect what we learned in Phase one. This does not however reduce the importance of "absenteeism" as an important variable, and we shall discuss it in more depth a little later in this section. We took out reduced productivity due again to the difficulty in measuring, with certainty, the role and level of influence of HIV/AIDS on this variable. We also treated "employee deaths" as a separate variable which will be discussed later.

Figure 30: Indirect Cost Comparison



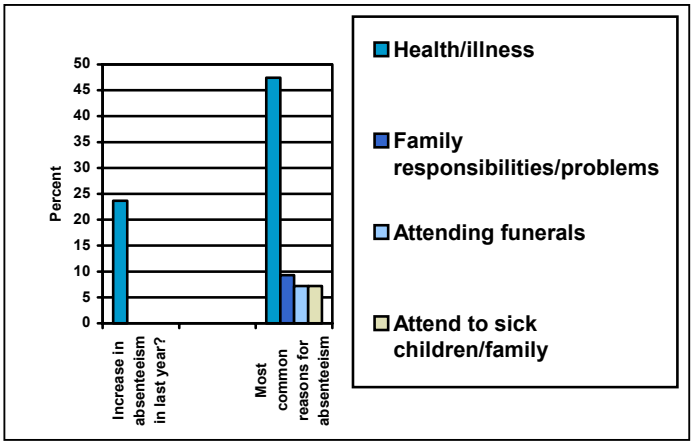
*N=97

7.5 Increase or decrease in absenteeism

Although there was a decline in the frequency of absenteeism cited as a cost in Phase two it was the most frequent indirect cost cited in this Phase, and therefore warrants more attention. We asked firms whether absenteeism had increased in the last year and found that over 23% of firms said that it had. We then asked firms what the most common reason for absenteeism was. We found that over 45% of firms cited health/illness, representing the largest portion by far of the responses. This was followed by family responsibilities/problems at nearly 10%, attending funerals (7,2%) and attending to sick children/family members (7,2%). Although it is very difficult and even risky to read too much into an observation of increased absenteeism over a year, the observation that health/illness is the primary reason being cited by firm respondents for absenteeism should be an indicator that firms should monitor more closely.

Certainly HIV/AIDS is a “health-related” matter, but then again the “flu” may be just the “flu”. We are not trying to draw a line from HIV/AIDS to the significant frequency of “health/illness” to an increase in absenteeism, given the difficulty in identifying, for certain, that the illness is HIV/AIDS-related. Rather putting the point across that the health and well being of employees should be considered important enough to plan for within SMEs, given the importance of maintaining production.

Figure 31: Comparison in Absenteeism

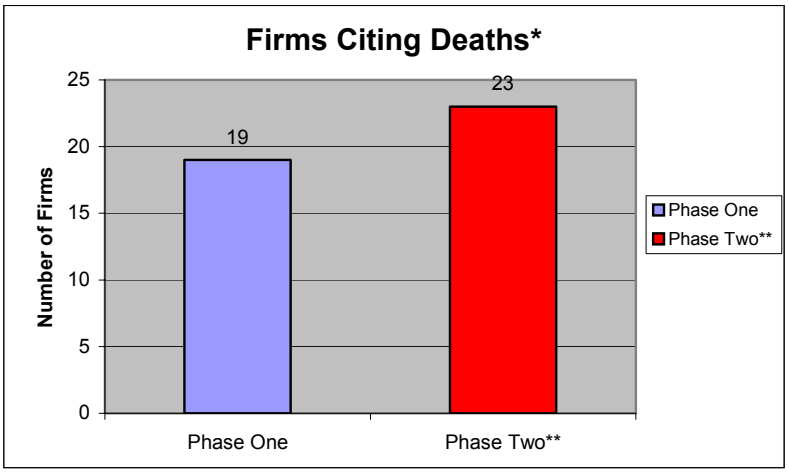


*N=97

7.6 HIV/AIDS related deaths of full time employees

This section compares the number of firms that indicated they had experienced HIV/AIDS related deaths between the two Phases.

Figure 32: Firms citing deaths



*N=97

As shown above, 19 firms cited deaths related to HIV/AIDS in Phase one as compared to 23 firms in Phase two. We can also report that three (3) firms reported having lost more than six (6) employees to HIV/AIDS in Phase two compared to only one firm in Phase one.

The figures may look insignificant in terms of change but when one takes into account the size of these firms, with the number of full-time employees ranging from just over five to below 200, the perspective may change. For instance if a firm looses one highly skilled person out of a labour force of six, that represents an important 17% of the workforce. Therefore taking the size of SMEs into perspective as well as the contributions of staff by skill and implications such as replacement

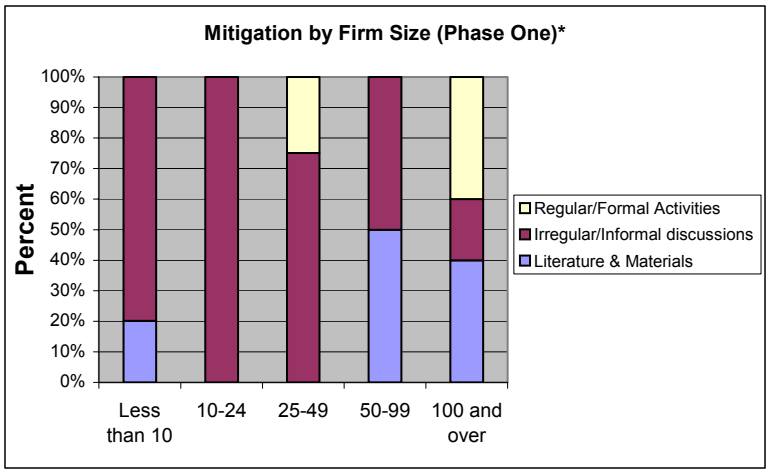
costs, reduced productivity and low staff morale is vital to appreciating the potential impact of HIV/AIDS on these firms.

In order to get even a better perspective of AIDS related deaths being experienced by the SMEs, we decided to put the following question to the respondents. “How many former employees have died of HIV/AIDS related illness in the last year?” To this question, we got an alarming number of 32 former employees who had died of AIDS related illnesses since our Phase one interview. This is a significantly high number of deaths given the small sample (120 firms) representing about 1% of the total full time employees. If one does not see any significance from the number of firms citing costs, this number of deaths within a relatively short period by a relatively small sample should be of great concern.

7.7 Mitigation activities

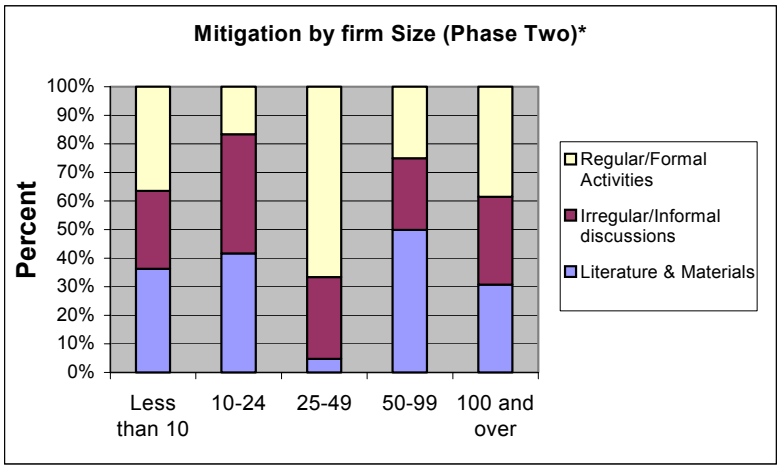
This section compares the firms in terms of mitigation activities by size of the firm. It is important in highlighting whether small firms are limited in what they can do to mitigate the effect of HIV/AIDS when compared to larger firms. We decided to look at this from the perspective of proportion of activities engaged in, as our primary interest is in investigating changes in the types and variety of mitigation activities present by size of firm. Figures 33 & 34 illustrate the data received from both Phases.

Figure 33: Mitigation by firm size (Phase 1)



*N=97

Figure 34: Mitigation by firm Size (Phase 2)



*N=97

We observed what we believe to be an encouraging sign between the two Phases, that of an overall increase in the variety of mitigation activities being engaged in, and in particular an increase in the proportion of more regular and formal types of mitigation activities, especially amongst smaller firms. We must, however, include the proviso and consider how we defined the three "types" of activities we used to measure mitigation activities between the two Phases.

The limitation in Phase one was that we were not very aware of the various types and meanings of HIV/AIDS workplace activities and so categorized them in the following rather limiting groupings:

Phase One

- Literature (posters) and Materials (condoms);
- Irregular and informal discussions; and
- "Formal" activities (regularity).

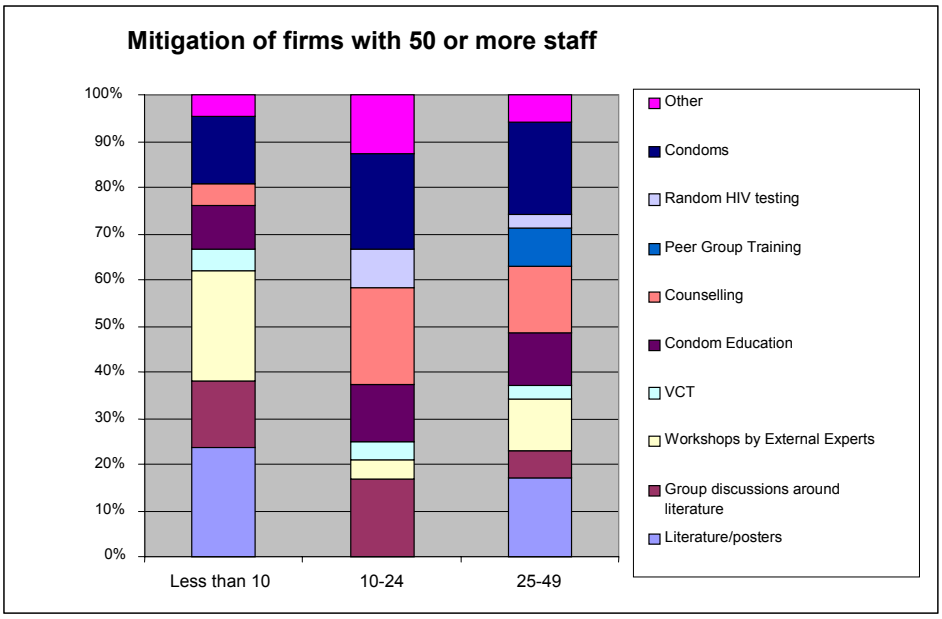
Identifying what constituted a "formal" activity was particularly problematic given the near absence of such "regular", "consistent", and more "organized" types of activities. In Phase two, with the benefit of more research and the realisation that we needed to start focusing more on what constituted an HIV/AIDS workplace "programme", we expanded the criteria of our list to include:

Phase Two

- Literature (posters) and materials (condoms);
- Irregular/informal discussions, group discussions on literature, condom education; and
- "Formal": workshops by external experts, counseling, peer group training, Voluntary Counseling and Testing, voluntary anonymous HIV testing, treatment for opportunistic infections.

Given the above, we were curious to see how firms of 50 (or fewer) employees faired with the proportion of mitigation activities in Phase two as compared with Phase one, which as illustrated in Figure 35, showed a preponderance of irregular/informal discussions. What we found was very encouraging, considering the variety of more "formal" types of activities being engaged in. For example we see very small firms of less than 10 employees bringing in external experts to workshop HIV/AIDS, we see condom education happening which is a particularly important accompaniment to the provision of condoms themselves, as well as counselling. These are positive occurrences that assist in the "formalisation" of workplace activities.

Figure 35: Mitigation of firms with 50 or more employees



8. CONCLUSIONS AND RECOMMENDATIONS

8.1 Key findings and conclusions

This section takes into account the findings from Phase one and two. We begin by highlighting the key issues that emerged as a result of the study. After discussing our main findings from this study, we then offer recommendations to stakeholders and interest groups who are likely to consider the findings of the study in their respective engagements with SMEs.

- Availability of workplace programmes

The study showed that there was an encouraging move by firms towards more "formal" types of workplace mitigation activities, however the challenge remains for firms to choose and "integrate" the types of activities in terms of "planning" based on the susceptibility and vulnerability profile of their companies. This should be a matter that SMEs themselves should address as part of their own business planning, but also should be addressed by HIV/AIDS workplace programme service providers.

- Constraints to mitigation

Most owner/managers (89.9%) showed a desire and willingness undertake actions to mitigate the effect of HIV/AIDS within their workplaces. The majority of these cited lack of time and/or a lack of skills to develop and manage such programmes as primary constraints. There is also limited awareness targeted at SMEs to help them understand how HIV/AIDS can affect them. We asked respondents to tell us whether they had obtained any information on HIV/AIDS targeted at SMEs, and the majority said "No".

- Costs Cited

Overall, problems with absenteeism proved to be the most common indirect cost across both Phases. It is not easy to say outright that this is due to HIV/AIDS but other factors such as the secrecy, stigma and the confidentiality surrounding the disease make it difficult to ascertain the impact of the pandemic. If one takes into account the fact that firms lost 32 employees since we last interviewed them, it further gives more merit to our conclusion that HIV/AIDS is having an effect.

- Firms in Durban (KwaZulu Natal) have cited more costs (relative to their representation in the sample) compared to firms in Cape Town who had cited the least effect.

- Gathering information only on firms citing costs does not adequately help in drawing conclusions on the potential impact of HIV/AIDS on SMEs. For instance, when we looked at the entire sample in terms of how susceptible and vulnerable they are with regard to the impact of HIV/AIDS, the majority of firms (including those not citing costs) had more than 50% of their employees within the most susceptible age group.

8.2 Recommendations

In this section we discuss our recommendations targeted at SME stakeholders and SMEs themselves. These stakeholders include, policy makers, implementers, private sector firms and others. These recommendations are not exhaustive but do capture key issues.

8.2.1 Policy making level

- There is need to increase the current level of awareness on HIV/AIDS with respect to small business. This could be done through presentation of findings of studies such as this one to decision makers in policy development. The motivation for doing so is the fact that on-the-ground information contributes to the development of relevant interventions. Key public sector SME stakeholders would include the Department of Trade and Industry (DTI), the Department of Health, Ntsika Enterprise Promotion Agency, provincial SMME Desks etc.

- There is need for closer co-operation between DTI and other “frontline” HIV/AIDS departments such as the Department of Health (DOH) and the Department of Education (DOE). The importance of such collaborations is not only to leverage resources but share information as well as infrastructure to speed up access of such information to SMEs.

- The study highlighted that most SME owners/managers are willing to put up workplace activities to mitigate the impact of the pandemic. We think DTI and other departments of the government can provide incentives to encourage SMEs to put up workplace programmes. For instance, government can request (within their SME procurement guidelines) SMEs to attach a copy of their workplace programme/policy as part of selection/award criteria. This can be a form of an incentive for those firms implementing HIV/AIDS workplace programmes, while government will be passing a message on how committed it is to addressing the pandemic.

- Ntsika supports the network of Local Business Development Centers (LBSCs) nationally. We think this available infrastructure would be key in disseminating information to SMEs. This also entails creating or increasing the awareness among the LBSC managers on how HIV/AIDS can affect SMEs. Ntsika has already indicated a willingness to use the network of LBSCs to disseminate the information to SMEs.

8.2.2 The private sector

- Business Chambers have a large database of SMEs, as they interact with many SMEs, they can be a key vehicle in disseminating information to SMEs regarding the impact of the pandemic.

- Besides creating and increasing the awareness about HIV/AIDS and business, the business chambers can share best practice in dealing with HIV/AIDS to SMEs.

- Big business are usually better equipped to fight the pandemic relative to SMEs. This is due to the fact that they have access to resources such as financial, skills, human and "more time" than SMEs. Depending on the type of business, large firms usually procure components or sub-components from SMEs. We propose that where such relationships exist, large business should encourage leveraging best practice with SMEs that supply them with goods and/or services. Because of the interdependency that exists in certain cases, this arrangement would ultimately benefit both large and SMEs.

8.2.3 Other stakeholders, donors, NGO's

- Those donors working with HIV/AIDS, education should start sharing best practice. They should also support the collaboration between SMEs and HIV/AIDS consultants and workplace service providers.

- Donors should also lobby government for policy modification (such as provision of incentives). Donors should support information sharing regarding the outcome of studies focusing on business and HIV/AIDS.

8.2.4 SMEs

- Other than just looking at whether or not they are being affected by HIV/AIDS, SMEs should take a step further, that is, to "risk profile" themselves. This means they should look at how susceptible and vulnerable they are to HIV/AIDS. We think this should be an important component of their planning exercise.

ECI is working towards developing a "susceptibility and vulnerability indicator" that SMEs can use to measure themselves against. Factors such as age, geographical location, industry sector, migrant labour will be used to measure susceptibility while the availability of mitigation activities or availability of resources to afford these interventions will measure their vulnerability to HIV/AIDS.